REPORT TO THE CONGRESS

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

Effectiveness Of Grant Programs Aimed At Developing Health Maintenance Organizations And Community Health Networks

Department of Health, Education, and Welfare

Office of Economic Opportunity

This report describes how effectively health maintenance organizations and community health networks, under programs initiated in 1971, had utilized their grants and suggests ways to improve such activities.

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COMPTROLLER GENERAL OF THE UNITED STATES
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To the President of the Senate and the
Speaker of the House of Representatives

This report describes how effectively health maintenance organizations and community health networks utilize their grants and suggests ways to improve such activities.

We made our review pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

We are sending copies of this report to the Director, Office of Management and Budget, and to the Secretary of Health, Education, and Welfare.

Comptroller General
of the United States

Contents

ABBREVIATIONS

APC	ambulatory patient care
CHN	community health network
HEW	Department of Health, Education, and Welfare
HIP	Health Insurance Plan of Greater New York, Inc.
HMO	health maintenance organization
HSA	Health Services Administration
HSMHA	Health Services and Mental Health Administration
HSP	Health Service Plan of Pennsylvania
MSHPO	Midsouthside Health Planning Organization, Inc.
OEO	Office of Economic Opportunity
RHN	Rochester Health Network
SPHA	South Philadelphia Health Action
SRS	Social and Rehabilitation Service
SSA	Social Security Administration
TAP	technical assistance planning

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

EFFECTIVENESS OF GRANT PROGRAMS AIMED AT DEVELOPING HEALTH MAINTENANCE ORGANIZATIONS AND COMMUNITY HEALTH NETWORKS

Department of Health, Education, and Welfare
Office of Economic Opportunity

D I G E S T

A health maintenance organization provides specific services to its members--either directly or through others--on the basis of prepaid rates. This provides a financial incentive for an organization to emphasize preventive medicine, reducing the overall cost of health care.

The Health Maintenance Organization Act of 1973 authorized $325 million for fiscal years 1974-77 to help develop health maintenance organizations. The act provided, in detail, the definition of and requirements for a health maintenance organization.

Earlier programs for planning and developing health maintenance organizations consisted of grants and contracts of the Department of Health, Education, and Welfare (HEW) totaling about $31 million and grants of the Office of Economic Opportunity totaling about $43 million to plan, develop, and operate 14 community health networks intended to be similar to health maintenance organizations.

GAO reviewed 38 projects under these earlier programs in California, Colorado, Illinois, Kentucky, Maine, Maryland, Massachusetts, Montana, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, and Rhode Island that had been awarded about $33.4 million.

As of October 1974, 11 of the 14 Office of Economic Opportunity community health networks were either operational or in the developmental stage. Only four were providing services on a prepaid basis. Prepaid enrollments ranged from 1,400 to 5,800 and totaled about 14,600. (See p. 8.)

The first goal of the program was to plan and operate health care organizations, similar to health maintenance organizations, in low-income areas serving 100,000 to 200,000 persons. Accomplishments have been minimal. (See p. 15.)

Based on an October 1974 status report, 35 HEW projects given financial assistance under the earlier program to develop health maintenance organizations had been designated as "operational." (See p. 9.)

Total enrollment was 200,000. About two-thirds of the projects were either serving less than 5,000 or primarily the poor, whose premiums were prepaid by Federal or State programs. (See p. 9.)

Accomplishments and problems of the 38 projects reviewed by GAO provide guidance on how HEW can better administer the new health maintenance organizations and continuing community health network programs. The following practices contributed to the success of some projects:

--Although many began to deliver services with fewer prepaid subscribers than forecast, the adverse impact of this situation was sometimes minimized by testing and revising marketing strategies based on experience. (See p. 13.)

--The experience of the most promising projects that used incentive-type third party marketing arrangements was more favorable than other grantees that also used third parties for marketing, but without similar financial incentives for successful performance. (See pp. 25 and 30.)

Conversely, some practices or conditions contributed to the uncertain or unsuccessful status of other projects:

--Overreliance by HEW projects on the Medicaid program as the initial primary source of health maintenance organization enrollees and financial support. (See p. 45.)

--The simultaneous provision of Federal financial support to two or more health maintenance organizations competing in the same areas for the same markets. (See p. 47.)

--The unsuccessful use of generator contracts by organizations to help other entities develop health maintenance organizations. (See p. 56.)

--The permitting of contractors and grantees to operate outside the scope of their agreements and providing continuing financial support to projects making little or no progress under their initial grants. (See p. 67.)

Community health network projects of the Office of Economic Opportunity were designed for low-income areas. A major factor slowing their development on a prepaid basis was the lack of access to the Medicaid enrollment market.

Financial management of Federal funds by grantees needed improvement, and HEW has taken action to more closely review financial aspects of grants, including making preaward assessments of grantee accounting systems and increased audits. (See p. 69.)

HEW should:

--Reduce the impact of unanticipated underenrollments of developing health maintenance organizations by (1) emphasizing preoperational marketing and enrollment activities and/or (2) making operational loans conditional upon an organization reaching a minimum enrollment level within a specific time. (See p. 15.)

--Give strong consideration to requiring applicants for initial development assistance that contemplate the use of third parties for marketing, to give third parties financial incentives for successful performance. (See p. 25.)

--Avoid situations where the project's starting marketing strategy is geared solely or principally to Medicaid recipients. (See pp. 48 and 49.)

--Avoid simultaneously funding the development of two or more competing health maintenance organizations in the same area where the organization concept is not already accepted by the community. (See p. 49.)

--Assure that sufficient progress has been made in meeting project objectives before providing additional funds or time for feasibility studies and planning projects. (See pp. 67 and 68.)

HEW generally agreed with the thrust of GAO's suggestions and emphasized that many had already been adopted in connection with the administration of the Health Maintenance Organization Act of 1973.

CHAPTER 1

INTRODUCTION

A health maintenance organization (HMO)[1] provides specific health services to its members--either directly or through others--and is compensated on the basis of predetermined prepaid rates. This feature distinguishes HMOs from most health care providers that charge for each service rendered.

Although growing in number, HMOs represent only a small portion of the health care and health insurance industry. Statistics published in February 1974 by the Social Security Administration (SSA), Department of Health, Education, and Welfare (HEW), show that in 1972, HMOs received about 4 percent of the total subscription and premium income of about $22.3 billion for all types of private health insurance. Blue Cross/Blue Shield plans received about 44 percent; commercial insurance companies, such as Aetna and Travelers, received about 49 percent; and other independent plans, such as employer-employee union groups, received 3 percent. Of the approximately 160 million people enrolled in private health insurance plans, only about 4 percent were enrolled in HMOs.

Of the 6.7 million people enrolled in HMOs in 1972, about 2 million belonged to employer-employee union groups,

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[1] According to a May 1974 statement of the National Academy of Sciences, the term "health maintenance organizations" was coined in 1970 as part of a health policy proposal aimed at strengthening the role of competition in the health care system and minimizing the role of regulation and planning. The term was subsequently adopted in the President's health messages to the Congress in 1971 and 1972. Although there are several statutory definitions for the term, it is generally used in this report in a broader sense to mean an organization that accepts, in exchange for a fixed advance capitation payment for voluntary enrolled subscribers, responsibility to provide specific health services, including at least ambulatory and hospital physician services and hospital care.

which generally served only employees or union members. Of the remaining HMO enrollees, about half, or 2.5 million, were enrolled in six Kaiser Foundation plans in Oakland and Los Angeles, California; Portland, Oregon; Honolulu, Hawaii; Cleveland, Ohio; and Denver, Colorado. HMOs with more than 100,000 enrollees in 1972 were the Health Insurance Plan of Greater New York (about 737,000 enrollees); the Group Health Cooperative of Puget Sound in Seattle, Washington (about 169,000 enrollees); and the Ross-Loos Medical Group in Los Angeles, California (about 103,000 enrollees). According to SSA, Blue Cross/Blue Shield had 756,000 subscribers, and commercial insurance companies had 64,000 subscribers enrolled in HMOs.

According to data compiled by HEW's Health Services Administration (HSA) in February 1974, the national enrollment in HMOs--exclusive of HMOs sponsored by employer-employee union groups--had increased by about 900,000 enrollees since the end of 1972, due in part to new HMOs.

NEW LEGISLATION TO DEVELOP HMOs

The Health Maintenance Organization Act of 1973 (Public Law 93-222) approved December 29, 1973, amended the Public Health Service Act to provide a trial Federal program to develop alternatives to the traditional forms of health care delivery and financing by assisting and encouraging the establishment and expansion of HMOs.

The act authorized $325 million for fiscal years 1974-77 for an HMO demonstration program to be carried out by

- --grants and contracts to public or private nonprofit organizations for HMO feasibility studies, planning, and/or initial development;
- --loans to public or private nonprofit organizations for initial operating assistance; and
- --loan guarantees to non-Federal lenders on loans made to private profitmaking organizations for planning, initial development, and/or initial operating assistance of HMOs serving the medically underserved.

Further, the act authorized $50 million for certain research and studies on quality of care.

Section 1301 of the act provided, in detail, the definition of and requirements for an HMO. The act specified (1) the basic and supplemental health services to be

provided to the enrollees, (2) the basis for fixing the basic prepaid capitation rates, (3) the conditions for members making nominal supplemental payments, (4) the conditions for reinsuring the HMO's financial risks of providing services on a prepaid basis, and (5) certain organizational requirements for an HMO.

In June 1975, because of lack of progress in developing HMOs under Public Law 93-222, legislation was introduced (H.R. 7847, H.R. 9019, and S. 1926) aimed at enhancing the ability of HMOs to competitively market their services to the public. The proposed amendments would make the formation of HMOs more attractive to potential sponsors and incorporate certain changes to improve administration and flexibility of the law. The proposed amendments would also extend the funding of HMOs for 2 years in recognition of the delays in implementation.[1]

AUTHORITY TO CONTRACT WITH HMOs UNDER MEDICARE

The Social Security Amendments of 1972 (86 Stat. 1329), approved October 30, 1972, authorized the Secretary of HEW--effective July 1, 1973--to contract with HMOs to provide Medicare services to beneficiaries who are enrollees. The amendment included certain quality assurance and financial responsibility standards for participating HMOs and provided for reimbursement limitations based, in part, on an HMO's cost of providing services.

PRIOR GRANT PROGRAMS TO DEVELOP HMOs

In his February 1971 and March 1972 health messages to the Congress, the President encouraged the establishment of HMOs as an alternative to the traditional fee-for-service health care delivery system. Consistent with this objective, HEW, during fiscal years 1971-74, and the Office of Economic Opportunity (OEO), during fiscal years 1971-73, awarded grants and contracts totaling about $73.6 million to organizations to provide financial and technical assistance in (1) planning and developing HMOs, and (2) developing and subsidizing organizations to provide health care for the poor under the HMO concept.

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[1] H.R. 7847 and S. 1926 would amend Public Law 93-222 to enable private organizations to obtain federally guaranteed loans for planning initial development and/or initial operating assistance to serve populations other than the medically underserved.

Because these projects were initiated and usually funded before the enactment of Public Law 93-222, they were not necessarily designed to meet the definition of and requirements for an HMO in that act.

We have been mandated by section 1314 of Public Law 93-222 to evaluate the operations, differences, and health impacts of HMOs which comply with the act's definitions and requirements. However, such evaluations are basically contingent on HEW accomplishing a primary goal of the act--the creation or expansion of HMOs. We are reviewing the progress and problems HEW is encountering in implementing the act and expect to give Congress information on

--an updated status of HMO development as an alternative health care delivery system;

--HEW management actions needed to accomplish congressional objectives efficiently and effectively;

--HEW's implementation of program reporting and evaluation requirements;

--legislative changes, if any, needed to accomplish objectives for HMO development; and

--the status of required GAO evaluations.

HEW's grant and contract efforts

During fiscal years 1971-74, HEW awarded about $22.3 million to 110 projects. The money was divided as follows:

--84 organizations were given grants totaling about $17 million to plan and develop HMOs.

--4 organizations were given generator contracts totaling about $1.2 million to assist organizations in the same geographic area interested in developing an HMO.

--6 organizations were given experimental health service delivery system contracts totaling about $1.2 million to examine and formulate innovative approaches to health care delivery, including the HMO concept.

--8 organizations were given grants totaling about $0.7 million to evaluate aspects of health care delivery related to the HMO concept.

--8 organizations were given grants or contracts totaling about $2.2 million to provide technical resources and perform research related to the HMO concept.

Some of these organizations also received funds under other HEW health programs as well as under OEO's Comprehensive Health Services program.

In addition, HEW awarded contracts totaling about $8.7 million to 43 organizations during fiscal years 1971-74 to (1) provide technical assistance, (2) evaluate program efforts, (3) study HMO resources nationally, and (4) identify key factors in HMO development.

Legislative authority for prior efforts

HEW awarded these grants and contracts under several sections of the Public Health Service Act:

1. Section 314(e)--to provide grants to any public or nonprofit private agency, institution, or organization to cover part of the cost of (1) providing services to meet health needs of limited geographic scope or of specialized regional or national significance of (2) developing and supporting, for an initial period, new programs for providing health services.

2. Section 304--to contract for research, experiments, or demonstration projects for developing new methods, or improving existing methods, of organizing, delivering, or financing health services.

3. Section 513--to use up to 1 percent of certain HEW appropriations for evaluation, either directly or by grant or contract, of various HEW programs.

4. Section 910(c)--to support research, studies, investigation, training, and demonstrations to maximize the utilization of manpower in delivering health services.

HEW also used section 1110 of the Social Security Act, which authorizes the Secretary of HEW to make grants to States and to public and other nonprofit organizations and agencies, to pay part of the cost of research or demonstration projects which will help improve administration and effectiveness of programs carried on or assisted under the Social Security Act.

Public Law 93-222 prohibits using funds appropriated under all other authorities of the Public Health Service

Act for the HMO financial support authorized under the new law.

OEO's grant efforts and legislative authority

Under the Comprehensive Health Services program, authorized by section 222(a)(4) of the Economic Opportunity Act, OEO[1] provided funds to develop organizations called community health networks (CHNs) which were intended to have many characteristics of HMOs. The goal of CHNs was to develop systems to provide health care for a population of 100,000 to 200,000 in low-income areas. The network model, tailored to meet local needs and conditions, was supposed to test whether an agency composed of health care providers and consumers could plan and operate a series of prepaid group practices in low-income areas. The CHNs were designed to market prepaid plans to low-income, near-poor, and nonpoor consumers.

During fiscal years 1971-73, OEO provided about $42.6 million to 14 organizations to develop and/or subsidize CHNs. Two of these organizations also received funds from HEW under its pre-Public Law 93-222 HMO development program.

HEW and OEO administration of prior efforts

The HEW grant program was administered principally by HEW regional offices, under the direction of HSA[2] and its component health maintenance organizations. In administering its HMO development program, HEW relied heavily on technical assistance planning (TAP) contractors in each region to provide expertise and technical assistance to HEW grantees and to monitor and report to the regional offices on the grantees' problems and progress.

The OEO grant program--except for a pilot program at the OEO Philadelphia regional office--was administered by its headquarters office in Washington, D.C. Effective July 6, 1973, the OEO grant projects were turned over to HEW for administration by a delegation of authority by the OEO

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[1]Name of agency was changed from OEO to Community Services Administration by Public Law 93-644, approved on January 4, 1975.

[2]Established as an HEW agency pursuant to a reorganization order, effective July 1, 1973. Before that time, the HMO grant program was under the direction of the Health Services and Mental Health Administration (HSMHA) which was abolished by the reorganization order. In this report, references to HSA also refer to its predecessor agency, HSMHA.

Director-Designate and approved by the President pursuant to section 602(d) of the Economic Opportunity Act. HEW has provided continued support to such CHNs under section 314(e) of the Public Health Service Act.

Projects we reviewed

We visited 38 projects in 14 States, with grants and contracts amounting to about $33.4 million or about 45 percent of the demonstration grants and contracts awarded by HEW during fiscal years 1971-74 and by OEO during fiscal years 1971-73. Of the 38 projects, 29 were funded by HEW, 6 by OEO, and 3 by both.

CHAPTER 2

OVERVIEW OF PROGRESS OF PRIOR PROGRAMS

The prior HEW program has had limited success in developing self-sustaining HMOs. The OEO-initiated program has made very limited progress in developing CHN projects into viable HMO prototypes, even on a subsidized basis. As of October 1974, HEW and OEO had designated as "operational" 43 projects assisted under these programs.[1] Generally, these projects were having difficulty marketing their prepaid plans to other than the medically indigent. HEW designated 35 projects as operational because they were providing services to about 200,000 enrollees on a prepaid basis, and OEO or HEW had designated 8 CHN projects as operational because they were providing medical services. All 8 CHNs were providing services on a fee-for-service basis and 4 of these were also providing services on a prepaid basis to about 14,600 enrollees.

OEO PROGRAM

As of October 1974, 11 of the 14 organizations given grants to develop CHNs were either operational or in the development stage. One CHN project with OEO grants totaling about $2 million had been terminated by HEW without ever becoming operational. HEW did not refund another operational CHN project which had received OEO grants totaling $4.8 million, and a third with $1.0 million in grants had been redirected to an ambulatory care center.

Of the 11 OEO-CHN projects, 4 (with grants totaling $18.3 million) were providing services on a fee-for-service and a prepaid basis and 4 (with grants totaling $11.4 million) were providing services on a fee-for-service basis. The remaining three (with grants totaling $5.1 million) were not operational.

Total prepaid enrollment in October 1974 in the 4 CHNs was 14,646--ranging from 1,400 to 5,850. As shown by the following table, HEW and/or OEO grants totally or partially directly subsidized the monthly capitation premiums of most of those enrolled in two of the four CHNs.

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[1]The designation of a project as operational under the prior programs does not mean that it meets the definitions of and the requirements for an HMO contained in Public Law 93-222.

CHN	Premium paid by Government	Partially by Government	Enrollee or employer	Medicaid	Total enrollees
Rochester Health Network, Rochester, N.Y.	-	-	2,736	-	2,736
Hunter Foundation, Lexington, Ky.	1,678	1,444	1,538	-	4,660
Northeast Valley Health Corporation, Mission Hills, Calif.	3,955	-	877	1,018	5,850
South Philadelphia Health Plan, Philadelphia, Pa.	-	32	1,260	108	1,400
Total	5,633	1,476	6,411	1,126	14,646

As of October 1974, three of the CHNs had been operational on a prepaid basis for over a year. The CHN in Philadelphia became operational in April 1974.

HEW PROGRAM

Of the 84 projects that received grants totaling $17.0 million to plan and develop HMOs, HEW had designated 29 with grants totaling $8.1 million as operational. HSA reported in October 1974 that the 29 projects had 177,000 enrollees.[1] Eighteen projects with grants totaling $4.7 million were still attempting to develop HMOs. Thirty-seven projects with grants totaling $4.2 million had been terminated or expired without developing HMOs. Six additional HMO projects with 23,000 enrollees that received technical assistance from HEW grantees or contractors had also been designated as operational.

Based on an October 1974 HSA status report, the total enrollees in these 35 operational HMOs were 200,094--ranging from 233 to 36,628. Eight of these with enrollments totaling

[1]According to an October 1974 HSA status report, seven operational projects and three ongoing projects had also received grants totaling about $2 million under Public Law 93-222.

36,132 were in nonmetropolitan[1] areas. Enrollment at three of the eight was limited to individuals who were Medicaid eligibles or whose premiums were paid by the Government. The remaining 27 HMOs were in metropolitan areas, and virtually all the enrollees at 7 of these were Medicaid eligibles. The enrollment of the 35 operational HMOs is summarized in the following table.

Enrollment in Pre-Public Law 93-222 Supported HMOs Designated Operational by HEW as of October 1974

Number of enrollees	Metropolitan				Nonmetropolitan				Total number of operational HMOs
	Medicaid only		Other		OEO eligibles or Medicaid only (note a)		Other		
	Number of HMOs	Enrollment	Number of HMOs	Enrollment	Number of HMOs	Enrollment	Number of HMOs	Enrollment	
Less than 2,000	1	872	7	4,380	-	-	3	4,425	11
2,000 through 4,999	2	4,103	4	12,908	3	8,524	-	-	9
5,000 through 9,999	2	10,985	8	60,392	-	-	1	7,883	11
10,000 through 14,999	-	-	1	11,694	-	-	-	-	1
15,000 and over	2	58,628	-	-	-	-	1	15,300	3
	7	74,588	20	89,374	3	8,524	5	27,608	35

[a]Enrollment generally limited to individuals or families with incomes meeting OEO poverty guidelines.

[1]Public Law 93-222 defines a "nonmetropolitan area" to mean an area no part of which is within a standard metropolitan statistical area as designated by the Office of Management and Budget and which does not contain a city whose population exceeds 50,000. Twenty percent of the funds authorized by the act are to be set aside for projects in rural areas, and at least two-thirds of the membership to be served by an HMO requesting rural assistance must reside in nonmetropolitan areas.

As of October 1974, 2 of the 11 HMOs with less than 2,000 enrollees and 3 of the 9 HMOs with from 2,000 to 4,999 enrollees had been in operation for 2 years or more. For example, Geisinger Medical Center, a nonmetropolitan HMO, was designated as operational in July 1972 when it began to enroll subscribers. It started to provide services in September 1972 with 333 enrollees. As of October 31, 1974, Geisinger had 1,611 enrollees compared with the original target of enrollment of 5,000. The enrollees included 1,349 of its own employees and their dependents. The Rhode Island Medical Society Physician's Service sponsored a metropolitan HMO which was designated as operational in May 1972 and in December 1972 had about 800 prepaid enrollees. A year later it had 1,080 prepaid enrollees and in October 1974 HSA reported it had 1,100 subscribers as compared with the original target enrollment of 4,000.

UNDERENROLLMENT A MAJOR OBSTACLE TO HMO DEVELOPMENT

Under its prior program, HEW designated HMOs operational once they had enrolled their first member and/or began providing services. Under the program authorized by Public Law 93-222, HEW has defined an "HMO" as an organization that is "qualified" under section 1310(d) of the act[1] and is delivering services in accordance with section 1301. (See p. 2.) Because initial enrollment campaigns for developing HMOs have often been implemented at about the same time the HMO became operational, we believe that HEW should have flexibility dealing with the consequences of unexpected underenrollments after an HMO starts to deliver services.

Under Public Law 93-222, HEW is authorized to make

--grants and contracts to public and private nonprofit organizations for HMO feasibility studies, planning, and/or initial development;

--loans to public and private nonprofit organizations for initial operating assistance; and

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[1] Section 1310 of the act requires employers to include in any health benefits plans offered its employees the option to join one or more qualified HMOs. Section 1310(d) defines a "qualified HMO" as one which meets or will meet certain organizational and service requirements of section 1310.

--loan guarantees to private profit organizations for planning, initial development, and/or initial operating assistance for HMOs that serve residents of medically underserved areas.

The loans and loan guarantees for initial operating assistance cannot exceed $1 million for any one year and $2.5 million for any single project. This assistance helps new HMOs meet operating expenses from the time they become operational until they obtain enough enrollees to break even (i.e., income equals expenses), but this time is not to exceed 3 years. Loans cannot be made unless HEW is assured that the HMO can pay principal and interest and will have the funds to complete the project. Loan guarantees cannot be made unless HEW determines that loans would not be available on reasonable terms and conditions without such guarantees. HEW regulations provide that only qualified HMOs are eligible for loans or loan guarantees.[1]

Neither the act, nor the conference report on it, specify when an HMO is considered operational for loan guaranty eligibility. However, HEW's regulations implementing the act state that the 36-month period for which loans and loan guarantees can be made begins with the first day of the month during which an HMO first provides services to members.

The marketing of any form of health insurance is facilitated when there is something in existence to sell--e.g., the capability to provide needed services and protection against the costs of a serious illness. Therefore, under the prior HEW and OEO programs, the dates that actual enrollment began were often closely correlated to or were no more than a few months before the dates that the projects started to deliver services. On the basis of prior programs' experiences, it seems unlikely that the prerequisite statutory assurances for qualifying for loans could be unconditionally met.

Although a few newly operational HEW projects did obtain significant enrollments upon or shortly after becoming operational, many HEW and OEO projects began to deliver services with fewer prepaid subscribers than forecast.

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[1]For the purpose of making loans and loan guarantees, HEW may determine that an entity is a qualified HMO if it proposes to become operational as a qualified HMO within 6 months of such determination and provides certain assurances to HEW.

Examples of the expected and actual initial enrollments for some operational projects were as follows:

Location of project and sponsoring agency	Operational date	Enrollment during first month of operations	
		Expected (note a)	Actual
Providence, R.I. (HEW)	May 1972	4,000	474
Sacramento, Calif. (HEW)	July 1972	5,000	[b]578
Danville, Pa. (HEW)	Sept. 1972	1,125	333
Lexington, Ky. (OEO)	Mar. 1973	1,000	400
Cambridge, Mass. (HEW)	July 1973	500	[c]500
Rochester, N.Y. (HEW)	Aug. 1973	10,000	881
New Hyde Park, N.Y. (HEW)	Dec. 1973	7,500	4,700
Havertown, Pa. (HEW)	Apr. 1974	1,900	[c]185
San Francisco, Calif. (HEW)	June 1974	1,000	462

[a]Forecast "initial" enrollment.

[b]Increased to 6,285 enrollees in August 1972.

[c]Estimate.

Newly operational HMOs experienced marketing problems which, while they might eventually be solved, did not provide an optimistic picture for financial success. For example:

--Enrollment campaigns and strategies needed to be implemented, tested, and revised based on experience. (See pp. 20, 22, and 41.)

--Larger scale group enrollment through employee groups or Medicaid did not materialize while individual members sporadically joined the plan through open enrollment. (See p. 34.)

In recognition of the uncertainty of an HMO as a financial enterprise and to provide safeguards to minimize the impact of unanticipated underenrollments, HEW should (1) emphasize the need for effective preoperational marketing, including testing of market forecasts by preoperational enrollment activity, and/or (2) make operational loans conditional upon an HMO reaching a minimum enrollment level within a specific time. Such steps could be augmented by providing grant assistance for completing

initial enrollment activities after designating an HMO as operational.

We believe that the use of grants for remedying marketing inadequacies--either before or after a developing HMO starts to deliver services--would be consistent with Public Law 93-222, which authorizes the implementation of an enrollment campaign as a function of initial development.

With regard to the requirement limiting loan guarantees to situations where reasonable loans would not be available without guarantees, we believe it would be more likely for a developing HMO to attract non-Federal financial support without such guarantees, after it had tested the reliability of its enrollment forecast and demonstrated the viability of its marketing approach.

The concept of establishing conditions for dealing with HMOs based on some minimum requirement criteria is not without precedent. The Social Security Amendments of 1972 (86 Stat. 1329) authorized the Secretary of HEW--effective July 1, 1973--to contract with HMOs for Medicare services to beneficiaries electing to join. The law and implementing regulations provide two reimbursement systems for HMOs--incentive reimbursement and reasonable cost reimbursement. Under incentive reimbursement, savings the HMO achieves are shared between the HMO and the Medicare program according to a formula in the law.

To qualify for incentive reimbursement, certain statutory requirements related to enrollment levels and operating experience must be met. An HMO in an urban area must (1) have been the primary source of health care for at least 8,000 persons in each of the 2 years immediately preceding the contract year, and (2) at the time of the contract with HEW have a minimum of 25,000 enrollees. The related statutory requirement for an HMO in a nonurban area is (1) that it has been the primary source of care for at least 1,500 persons in each of the 3 years immediately preceding the contract year, and (2) at the time of the contract with HEW has a minimum of 5,000 enrollees.

We recognize that setting a minimum enrollment figure as a condition for making loans may be difficult because of limited experience under Public Law 93-222 and varying circumstances. However, loan applicants are required to submit detailed information on enrollment forecasts; therefore, minimum enrollment levels could be set at some percentage of the forecast initial enrollment.

CONCLUSIONS

In relation to the initial goals of the OEO-initiated CHN program--to plan and operate a series of prepaid group practices in low-income areas serving populations of 100,000 to 200,000--the accomplishments have been minimal. Of the 14 original CHN projects, 3 had been dropped or redirected by HEW as of October 1974, and of the remaining 11 projects, only 4 were providing services on a prepaid basis--and these to about 12,500 enrollees.

HEW's pre-Public Law 93-222 HMO development program has made some positive impact. Despite delays and disappointing starts, HSA reported in October 1974 that about one-third of the 84 projects receiving grants to plan and develop HMOs had managed to reach the operational stage and were providing services to 177,000 enrollees. However, about half of these belonged to HMOs where the subscribers were generally limited to Medicaid eligibles whose premiums were paid by that federally assisted program or to individuals whose premiums were paid by OEO or HEW grants. Over half the other HEW-initiated HMO projects were small operations with less than 5,000 enrollees, which indicates that under HEW's prior program, low enrollments represented a major obstacle to the development of self-sustaining HMOs. In many cases, the severity of the marketing problems was not apparent until the projects began to provide services.

RECOMMENDATIONS TO THE SECRETARY OF HEW

To minimize the impact of unanticipated underenrollments of developing HMOs, we recommend that in implementing Public Law 93-222, HEW emphasize preoperational marketing and enrollment activities and/or make operational loans conditional upon an HMO reaching a minimum enrollment within a specific time.

AGENCY COMMENTS AND OUR EVALUATION

In a letter dated July 22, 1975 (see app. III), HEW said it was in general agreement with the thrust of our recommendations. HEW stated that it believed the regulations, guidelines, and procedures established to implement the Health Maintenance Organization Act of 1973 would accomplish the intent of the recommendation without the need for additional changes.

Concerning our recommendation emphasizing preoperational marketing and enrollment activities, HEW said that the funding under the initial development grant authority is adequate for testing consumer attitudes and for developing and testing

marketing strategies. HEW added that during the initial development activity, HSA closely monitors the progress of a grantee in developing its marketing capability. HEW pointed out that these activities, coupled with the provision in section 1310 of the act requiring employers to offer an HMO as an optional health benefits coverage and the increasing awareness of HMOs among employers and the public, should insure better marketing efforts.

Concerning our second recommendation, HEW said that it did not agree that operational loans should be conditional upon an HMO reaching a minimum enrollment level within a specified time. They said that an organization could be a qualified HMO and receive an operational loan before becoming operational, and that, in many cases, this will be necessary to assure that the grantee has adequate financial backing to enroll persons and become operational.

HEW said, however, that the decision to make a loan would be contingent upon HEW's evaluation of the applicant's marketing forecast and that, after a loan is committed, the progress of the HMO's enrollment efforts would be closely monitored. If the HMO's enrollments fall behind its projections, HEW will provide technical assistance to change the HMO's marketing approach and techniques. If the HMO continues to fail to meet the necessary enrollment goals, thus indicating an inability to become a viable organization, the project can be terminated resulting in a minimum drawdown on the principal amount of the loan.

HEW stated, and we agree, that this approach meets the general intent of our second recommendation.

Also, we agree with the approach taken by HEW in response to our recommendation for preoperational marketing and enrollment activities, because some HMO's we reviewed under the prior program did begin operations with marketing forecasts which subsequently proved overly optimistic when the HMO actually started operations or began to enroll members. Therefore, the testing of such marketing strategies through actual enrollments during the initial development phase seems to us a more viable alternative than limiting initial development marketing activity to developing a grantee's marketing capability.

CHAPTER 3

MOST PROMISING GRANT PROJECTS

Of the 38 projects visited, 3 HEW-assisted grantees appeared to have the most promise for becoming self-sustaining HMOs--the Harvard Community Health Plan at Cambridge, Massachusetts; the Genesee Valley Group Health Association, Rochester, New York; and the Long Island Jewish-Hillside Medical Center, New Hyde Park, New York. Although there is no assurance that these projects could meet the definitions of or the requirements for an HMO contained in Public Law 93-222, they seemed to have the capability of becoming self-sufficient without continued Federal assistance.

Among the factors which favorably affected our classification of these three projects as most promising were the following:

--One project (Harvard) had been operating as an HMO in an adjacent city and had obtained experience which helped the grantee recognize and avoid potential problems.

--All three projects arranged to provide services with providers, particularly physicians and hospitals.

--All three projects had developed comprehensive benefit packages and capitation rates and had marketing arrangements with third parties featuring financial incentives (including, in one case, a substantial investment) to encourage successful performance.

--All three projects were attempting to bring Medicaid recipients into their plans as a supplement to a firm base of private enrollees, and one project (Harvard) had obtained a State contract to provide services to Medicaid recipients on a prepaid basis and had enrolled some of them.

--All three projects had obtained significant funds and/or guarantees from non-Federal sources to help construct, renovate, or equip medical facilities and/or to offset initial operating losses.

A discussion of these three projects, based principally on data obtained during our visits and interviews with grantee officials, follows.

HARVARD COMMUNITY HEALTH PLAN--CAMBRIDGE

The Harvard Community Health Plan is a prepaid group practice plan founded by the Harvard Medical School. The plan was incorporated in 1969 as a charitable nonprofit corporation and is a legal entity distinct from the medical school and its affiliated hospitals.

Since October 1969 the plan has been providing services to enrollees on a prepaid basis in a health center in Boston. HSA reported in October 1974 that the enrollment at the center was about 34,400. Beginning in June 1971 the plan received three HEW grants totaling $422,439 to help develop a second health center in the adjacent city of Cambridge. In July 1973 the plan began providing prepaid services to enrollees in Cambridge. HSA reported in October 1974 that the enrollment at Cambridge was about 5,800.

On the basis of the experience gained at the Boston health center, the plan developed its marketing strategy and prepared benefit packages and capitation rates for the Cambridge center.

Arrangements to provide services

Most physician services were provided by salaried employees--five full-time and nine part-time physicians at the Cambridge health center. Inpatient services for Cambridge members are provided under contract by a Cambridge and a Boston hospital. Both are teaching hospitals affiliated with the Harvard Medical School.

Although the physicians in fee-for-service practice in Cambridge opposed the Cambridge HMO program, the plan was supported by the Cambridge community and was able to recruit enough physicians to staff the center.

Benefit packages and capitation rates

The plan used the same benefit packages and capitation rates for the Cambridge health center that were being used for the Boston health center.

The standard benefit package includes an unlimited number of hospital days, physician and nursing services, diagnostic lab and X-ray tests, intermediate care, and home health care. A $1 charge is made for health center visits. This package (without copayments) is offered to Medicaid recipients, and a low option benefit package, which contains deductible and copayment clauses, is also available through two commercial (non-Blue Cross) insurance companies.

The plan has two categories of capitation rates--one for adults and one for children. The monthly capitation rates are the amounts Blue Cross, certain insurance companies, and the State Medicaid agency remit to the plan. Blue Cross and the insurance companies convert the capitation into monthly premium charges, which for Blue Cross were $25.39 for single individuals and $69.33 for families from October 1973 to September 1974.

The premiums charged by Blue Cross for the plan were competitive with those charged for the best selling plan offered by Blue Cross/Blue Shield, which was $24.50 and $65.50 for individuals and families, respectively, for the quarter ended March 1974.

Medicaid enrollees

Since July 1, 1970, the plan has had a contract with the Massachusetts Department of Public Welfare to permit public assistance recipients to join the plan.

The contract had an indefinite termination date and provided that a maximum of 5,000 recipients can be enrolled from the Greater Boston area. As of October 31, 1974, 2,167 recipients were enrolled--1,848 at the Boston health center and 319 at the Cambridge health center.

Non-Federal financial assistance

The plan obtained financial assistance from non-Federal sources to help develop the Boston health center. Through September 1972 the plan obtained, in addition to Hill-Burton and other HEW grants of about $1.1 million, grants totaling $500,000 from the Rockefeller Foundation and the Commonwealth Fund, and loans totaling about $2.5 million from Harvard University, the Ford Foundation, and a commercial bank. These funds were used to renovate and equip the Boston health center and to offset initial operating deficits. In its first 4 years of operation (Oct. 1, 1969, to Sept. 30, 1973), the plan incurred about $3 million in operating losses and invested about $1.6 million in facilities.

Including equipment, the planned health center in Cambridge was to cost an estimated $3.8 million. Construction financing of up to $2.7 million had been arranged with a commercial bank, and a commitment for long-term financing had been obtained from an insurance company. Lease arrangements had also been made to finance the acquisition of equipment valued at $600,000. The remaining funds were to be provided by a non-Federal grant of $300,000 and by $200,000 from plan revenues.

The plan had also obtained two non-Federal grants totaling about $827,000 from the Robert Wood Johnson Foundation to help finance operating losses at the Cambridge health center through March 1976.

Marketing

The plan has been offered to employee groups as an option by Blue Cross and 10 commercial insurance companies. In addition, the plan is available under the Federal Employees Health Benefits program. Marketing was done by Blue Cross and staff members of the Harvard Plan. Generally, the marketing strategy consisted of:

--Persuading employers through personal contact to offer the plan as an option through existing arrangements with established health insurance carriers.

--Encouraging employees to select the plan once an employer has agreed to offer it. This involved presentations to management and employee groups, giving tours of the plan's facilities, and providing orientation sessions for new members.

When the plan in Boston began to provide services in October 1969, Blue Cross and the insurance companies had exclusive rights to market it. Plan officials expected an enrollment of 10,000 by the end of the first month, but only 88 persons had enrolled. By the end of the third month--December 1969--the enrollment had increased to only 489. Therefore, the plan revised its marketing strategy in early 1970 by abandoning exclusive third party marketing and developed its own marketing staff to sell the plan to both employers and employees. This was successful and by December 1970 the enrollment had increased to about 7,700.

In early 1971, Blue Cross concurred that the plan's marketing approach was more effective. Blue Cross agreed to maintain a marketing staff trained by the plan and guarantee a certain enrollment level. A recent quota agreement required Blue Cross to gradually increase the enrollment for the Boston and Cambridge centers by 8,000 between December 1973 and September 1974. If Blue Cross does not meet the enrollment quota for a particular month, it must pay the Harvard Plan $9 (75 percent of the medical portion of the capitation rate) for each person under the quota. As of June 1974, Blue Cross had reached its quota each month.

GENESEE VALLEY GROUP HEALTH ASSOCIATION

For the period July 1971 through December 1973, HEW awarded the Group Health Foundation, Washington, D.C.--as agent for the Blue Cross Association, the National Association of Blue Shield Plans, and the Group Health Association of America--two grants totaling $546,650 to help the local Blue Cross/Blue Shield organizations in Rochester develop a prepaid group practice plan. Rochester was selected because its Blue Cross and Blue Shield plans (Rochester Blues) were willing to make a commitment to this effort. The Rochester Blues established the Genesee Valley Group Health Association, a nonprofit health services corporation. The association began enrolling on a prepaid basis in July 1973.

Arrangements to provide services

The association negotiated with a physician who, as an independent contractor, was responsible for recruiting physicians and forming a medical group. As of November 1, 1974, the medical group had 10 full-time and several part-time physicians at 1 ambulatory care center. The medical group is to be organized as a business entity, and the medical director must attempt to negotiate a medical service contract between the medical group and the association. Inpatient care is normally provided by the Rochester General Hospital under a contract with the association.

Benefit packages and capitation rates

The association offered a comprehensive health benefit package, including 120 days' hospitalization or extended care services, physician services, diagnostic lab and X-ray services, allergy tests, and hearing and eye examinations. Charges of $2 and $5 were made for visits to the health center and for house calls, respectively. However, the association's monthly capitation rates of $17.42 for an individual and $49.68 for a family were generally from 30 to 50 percent higher than the Blue Cross/Blue Shield group premiums in the Rochester area.

Medicaid enrollees

An association official said it had not attempted to negotiate a prepaid contract with the State Medicaid agency because it wanted to get a firm base of private enrollees (20,000) before reaching agreement with State officials covering the enrollment of Medicaid recipients on a prepaid basis. However, in August 1974 the association was treating Medicaid beneficiaries at its health center on a nonprepaid basis at negotiated rates.

Non-Federal financial assistance

The Rochester Blues paid about $3.3 million to construct and equip the new health center which the association leased. The Rochester Blues have also agreed to loan the association funds to finance its first 2 years' operating losses.

Marketing

The Rochester Blues marketed the association's plan and two other prepaid health plans simultaneously. (See p. 32.) Marketing efforts concentrated on 21 employers having a total of about 54,000 workers. The association expected an initial enrollment of 10,000, mostly from 1 employer of about 47,000 persons. Only 881 persons were initially enrolled by August 1973, including 468 from the 1 large employer and 112 employees from Blue Cross. According to HEW and/or association officials, the association did not attain its goal because:

--The Rochester Blues marketed the three prepaid plans impartially.

--Prepayment is a new concept to Rochester which requires aggressive selling and marketing personnel who are advocates of the program.

--The largest employer required employees to fill out a form only if they desired to change from their present health plan rather than requiring them to fill one out regardless of whether they wanted to change their present health plan.

--Most of the companies offering the prepaid plans required employees to pay a high percentage of the monthly premiums.

To increase enrollment, the association established its own marketing staff in October 1973 to sell the plan to smaller companies in the Greater Rochester area that were not offering the other two prepaid plans. By December 1973, the enrollment had increased to 2,300 and by October 1974, the enrollment was about 9,500.

Although the project has encountered marketing problems and its capitation rates appear high in relation to premiums of other group health insurance in the area, we have classified it as promising, primarily because of the financial investment and commitments made by the Rochester Blues.

LONG ISLAND JEWISH-HILLSIDE MEDICAL CENTER

This center includes a 450-bed teaching hospital and a 200-bed psychiatric hospital in New Hyde Park.

In January 1972 HEW awarded the center a 1-year $84,641 grant to develop a prepaid hospital-based group practice as an HMO model. In February 1973 HEW awarded a $116,258 grant to continue the development of a hospital-based HMO. When the center submitted its initial proposal, the grantee had a verbal commitment from the Associated Hospital Service of New York (Blue Cross) to supply a starting prepaid enrollment of 10,000 to 15,000 members, provided the planning process was successful. This arrangement was changed to an enrollment guarantee of 7,500 enrollees. Blue Cross would subsidize the center for enrollees under that number.

On December 1, 1973, the HMO--known as the Community Health Program of Queens-Nassau Incorporated--began to provide services on a prepaid basis to about 4,000 enrollees. HSA reported in October 1974 that the enrollment had increased to about 7,000.

Arrangement to provide services

Physician services are provided by salaried physicians at a health center adjacent to the center. Hospital services are provided by the center and other Blue Cross-affiliated hospitals in the area. The hospitals are paid the Blue Cross per diem rate for inpatient services.

Benefit packages and capitation rates

The HMO has a comprehensive benefit package with both a low and high option. The high option with monthly capitation rates of $23.40 for an individual, $46.80 for two persons, and $70.20 for a family of three or more includes physician services, immunizations, laboratory and X-ray outpatient care at the center; ambulance service when approved by a group physician; and 30 days of psychiatric care.

In contrast, the Blue Cross/Blue Shield premiums for the health insurance plans offering the broadest coverage for group subscribers in the Greater New York City area were about $16.50 for an individual and $41 for a family. The HMO's low option package generally provides the same coverage as the high option but with deductibles and copayments.

Medicaid enrollees

The grantee has had discussions with local Medicaid officials regarding a prepaid contract. However, as a precondition to such an arrangement, the center was to develop a base of 5,000 private enrollees before entering into an agreement to accept Medicaid beneficiaries on a prepaid basis.

Non-Federal financial assistance

Blue Cross collects the capitation rates from enrollees or employers and reimburses the HMO for the budgeted cost in accordance with a capitation schedule made part of its contract with the HMO. Because the budgeted cost per enrollee at an enrollment of 4,000 exceeded the capitation rate, Blue Cross in December 1973 was subsidizing the HMO $7.68 per enrollee per month. Further, Blue Cross paid the HMO $15.43 per month for each enrollee below 7,500. This represents the low option plan cost for an enrollment of 4,000 of $28.98 less $13.55, the budgeted low option cost of inpatient hospital care. Blue Cross had agreed to continue this latter arrangement with varying levels of subsidy until the enrollment reaches 25,000, which is expected to be reached by December 1976.

Marketing

Blue Cross markets the plan to employers of five or more employees living within an 8-mile radius of the center. The HMO plan is offered to current Blue Cross group subscribers as an option, and HMO officials estimate that the marketing effort will reach about 300,000 people of an estimated 1.2 million in the service area. The HMO needs about 22,000 enrollees to break even and had estimated that enrollment would be 11,000 at the end of the first year of operation.

CONCLUSIONS

Major factors contributing to the potential success of the three organizations discussed in this chapter have been their ability to (1) make service arrangements with physicians, hospitals, and other providers, (2) obtain access to large groups of potential enrollees, and (3) obtain non-Federal financial assistance for facilities and initial operating losses.

All three organizations recruited physicians--two employed physicians as salaried employees, and one is contracting for physician services with a medical group.

Two of the three projects obtained non-Federal financial assistance for facilities, equipment, and operating losses, while one project received financial assistance in the form of payments for a guaranteed enrollment.

The capitation rates developed for two of the three projects were high in comparison with other fairly comprehensive health insurance plans available in the area. This would necessitate aggressive marketing to sell the HMO concept and any improved benefits available under it.

Marketing and enrollment for the three projects was done primarily by or in conjunction with Blue Cross/Blue Shield or commercial insurance carriers. When the Rochester Blues participated in the marketing and enrollment efforts, there were financial incentives to make such efforts successful in the form of enrollment guarantees or quotas or a substantial financial investment. Also, two of the three projects supplemented third party marketing with their own staffs. It is significant to compare the experience of these more promising projects with the less favorable experience of other grantees discussed in the next chapter that also used third parties for marketing, but without similar financial incentives for successful performance.

A key to demonstrating the feasibility of an HMO project is the soundness of its marketing approach and the commitment made to its success. Therefore, if an HMO applicant's marketing is to be handled by third parties, such as health insurers, it would be desirable for the HMO to incorporate in its arrangements with such third parties appropriate financial incentives such as quotas or enrollment guarantees to encourage performance.

RECOMMENDATION TO THE SECRETARY OF HEW

We recommend that, in considering grants, contracts, or loan guarantees for the initial development of HMOs under Public Law 93-222, for those applicants whose marketing plans contemplate the use of third parties, HEW should give strong consideration to requiring such applicants to give the third parties financial incentives for successful performance.

AGENCY COMMENTS AND OUR EVALUATION

HEW did not agree that it should require HMOs using third party marketing agents to provide the third parties with financial incentives for successful performance. HEW said that the involvement of carriers with substantial resources and access to the marketplace can be an important factor in the growth and financial viability of a new HMO.

HEW agreed that to capitalize to the maximum on carrier resources, the carrier should have real incentives for successful performance; but added that it might not be possible for an HMO to secure an agreement containing such provisions with a carrier, and the advantages of having a marketing agreement with such a carrier could outweigh the disadvantage of not being able to include incentive provisions in the agreement. HEW believed each case should be reviewed individually and HMOs encouraged to include financial incentives wherever possible.

We recognize that it may not be possible in all cases for HMOs to obtain agreements containing financial incentives with third party marketing agents. Nevertheless, in view of the experience under the prior program we believe that, in such circumstances, the applicants should clearly demonstrate that the advantages of using a particular third party marketing agent outweigh the disadvantages of not being able to include incentive provisions in the agreement.

CHAPTER 4

UNCLASSIFIED GRANT PROJECTS

We did not classify 18--or about half the projects reviewed--as either potentially promising or unsuccessful. These projects included 13 which were operational on a prepaid basis as of October 1974. An unclassified project is one for which there was serious doubt about its ability to develop as a viable HMO without substantial Federal financial support or, in the case of six OEO-initiated CHNs still active in October 1974, there was doubt as to the projects' ability to enroll sufficient members on a prepaid basis to be termed successful even with continued subsidies. This did not mean that the projects would fail or that some CHNs were not providing worthwhile and needed ambulatory health services through their neighborhood health centers. It meant that at the time of our fieldwork, the projects lacked characteristics essential to a viable HMO operation or:

--Had a marketing strategy geared solely or principally to Medicaid recipients, but difficulties had been encountered in obtaining prepaid Medicaid contracts.

--Had low enrollments for operational projects.

--Lacked financial support for underfinanced projects.

--Lacked firm arrangements with key providers (e.g., hospitals and physicians).

--Lacked financial plans and related benefit packages and capitation rates.

--Had significant slippages in meeting grant objectives.

Other factors which entered into our evaluations included:

--Organizational and staffing problems.

--Competition from other developing or operational HMOs in the area.

--The stigma reportedly attached to OEO-funded CHN projects geared to serve the poor.

Appendix I[1] lists the 18 projects, along with brief summaries of their status and problems.

OVERVIEW OF STATUS AND PROBLEMS

Of the 18 unclassified projects, 6 were OEO-initiated CHNs and 2 were OEO-HEW-funded rural projects developed on a prepaid basis. The remaining 10 were HMO-development projects funded by HEW.

The basic objectives of the OEO-initiated CHN projects--which were designed to provide subsidized comprehensive health services on a prepaid basis principally to the poor or near-poor--differed from those of the HEW-funded projects, which were aimed at developing self-sustaining HMOs. We considered such differences in our evaluations.

OEO-initiated CHNs and rural projects

The status of the eight projects reviewed as of October 1974, which were principally supported by OEO, is summarized as follows:

Year becoming operational on a prepaid basis	Project Type	Number
1972	Rural	2
1973	Urban CHN	2
Through October 1974	Urban CHN	1
Total operational		5
Developmental	Urban CHN	3
Total		8

Operational projects

Of the five operational projects, four had not negotiated prepaid Medicaid contracts in their States as contemplated by their grants. The negotiations for the Medicaid contract that was entered into by one project involved a period of about 2-1/2 years.

The two rural OEO-HEW-funded projects in Maine, which

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[1]As noted in appendix I and in this chapter, information obtained after our fieldwork indicated that several projects had made some progress in resolving their problems, including one in particular (Rocky Mountain Health Maintenance Organization in Grand Junction, Colorado) that became operational in January 1974 and appears to be potentially successful. (See p. 89.)

became operational in 1972, had not met the objectives of their grants because they had not expanded their prepaid enrollment beyond those individuals meeting the OEO poverty income criteria for whom there was a 100-percent Federal subsidy.

The two urban CHN projects, which became operational in 1973, experienced underenrollment. One project (Rochester) was initially marketed in July 1973 by Blue Cross/Blue Shield to employee groups where the project was competing with two other HMOs. One of these was an HEW-funded projects sponsored by Blue Cross/Blue Shield offering comparable benefits at lower rates. The second CHN (Lexington), which began delivering services in March 1973, started off with an inadequate marketing program. Officials of both projects said that the stigma that the CHNs were for the poor hampered their ability to market their programs.

The third urban CHN project (Philadelphia) became operational in April 1974 and by October 1974 had 1,400 prepaid enrollees as compared with an earlier projection of 3,250 by the end of 6 months of operations.

Developmental projects

Three urban CHNs were operating on a fee-for-service basis but not on a prepaid basis as of October 1974. Of these projects, none had negotiated contracts on a prepaid basis with the State Medicaid agency, although at two projects (Chicago and Cincinnati), such negotiations had been initiated in February 1972 and January 1973, respectively. All three projects faced potential or actual competition from other HMO development projects--including two (Chicago and Sacramento) which were competing for the Medicaid enrollee market with HEW-funded projects. For all three developmental CHN projects, the scheduled operational dates had slipped for a year or more because of the inability to meet grant objectives.

HEW-funded HMOs

The status, as reported by HSA in October 1974, of the 10 HEW projects which we did not classify as either potentially successful or unsuccessful is summarized as follows:

Year becoming operational	Number of projects
1972	3
1973	1
Through October 1974	4
Total operational	8
Developmental	2
Total	10

Operational projects

To become a self-sustaining HMO operation, an organization must obtain enough subscribers to support the facilities and staff needed to provide comprehensive care. Before the enactment of Public Law 93-222, HEW had estimated that HMOs in urban areas with their own facilities might require an enrollment of 25,000 to 30,000 to break even, whereas HMOs in rural areas might be able to break even with an enrollment of 10,000 and still provide a reasonable range of services.

Three of the four HEW projects becoming operational in 1972 and 1973 experienced serious underenrollments and, in all three instances, Blue Cross or Blue Cross/Blue Shield were used to handle the marketing; but without the financial incentives for performance applicable to the projects discussed in the previous chapter. The fourth operational project (see p. 86) was successful in marketing its prepaid plan to Medicaid recipients only--as planned--but had not demonstrated its ability to market the plan to others. In addition, this project reported it had experienced heavy initial operating losses under its Medicaid contract with only limited outside financial resources to meet them.

Of the four HEW projects becoming operational in 1974, two (Havertown, Pa., and San Francisco, Calif.) had respective enrollments of about 200 non-Medicaid subscribers and about 900 Medicaid subscribers as reported by HSA in October 1974. The projects had been operational 6 and 4 months, respectively, and the projected enrollments were about 7,000 or 8,000 for comparable periods of operation. In October 1974 the third project (Chicago) was operational for a month with 2,000 Medicaid enrollees as anticipated. The fourth project (Grand Junction) had slightly exceeded a July 1973 estimate of 7,500 Medicaid and other subscribers for the first year of operation.

Planned operational dates for the four projects had slipped from about 6 months to 2 years. The initial marketing strategy for three of the projects was geared solely or

principally to Medicaid recipients, and the slippages were primarily caused by difficulties and related delays in negotiating prepaid contracts with the State Medicaid agencies, which involved from 1 to 2 years. The slippage in becoming operational at the other project (Havertown) was attributed by an HEW official to a lack of funds and to difficulties in negotiating service agreements with hospitals. Two projects (Havertown and Chicago) faced potential or actual competition from CHNs attempting to develop in the HMO mode in the same areas.

Developmental projects

Two unclassified HEW-funded HMO projects were not operational in October 1974. The initial planned operational dates slipped about 2 years. One project (Garden City, N.Y.), with an HSA grant expiring in September 1974, had firmed up agreements with physicians. However, other necessary arrangements, such as agreements with hospitals for providing services, the development of firm benefit packages and capitation rates, and marketing plans, appeared to be contingent on finalizing negotations with an insurance company. This project also faced competition from an operational HEW-funded HMO project in its service area. The other project (Orange, N.J.), whose HSA grant expired in December 1974, had developed benefit packages and capitation rates but had not firmed up service arrangements with physicians and hospitals.

DISCUSSION OF SELECTED PROJECTS

A discussion of the status of and problems encountered by two operational OEO-initiated CHNs, one OEO-HEW-funded rural project, and two operational HEW-funded HMO projects follows.

Rochester Health Network (RHN)--
OEO-initiated CHN

RHN comprised four neighborhood health centers and a medical foundation. The foundation included about 70 percent of the physicians in Monroe County. Each center was an independent corporate entity and was affiliated with major hospitals in the area. The four centers served about 30,000 people on a fee-for-service basis before RHN also began to provide prepaid services in August 1973.

OEO awarded RHN a $3.2 million grant in June 1971 for July 1971 through June 1973 to establish and maintain a network of comprehensive health centers in Monroe County. The grant contemplated the development of an HMO concept operation based on prepaid capitation rates. In March 1973 RHN received an additional OEO grant for about $3.7 million to

cover operating losses for April 1973 through March 1974. HEW has funded the project with a $4 million grant to cover April 1974 through March 1975.

Under the second OEO grant, the projected prepaid enrollment, as of April 1974, was to be 21,200--10,500 Medicaid recipients, 5,350 partial-pay enrollees, and 5,350 full-pay enrollees. Although initially geared to primarily serve Medicaid eligibles, a prepaid Medicaid contract had not been signed as of October 1974.

The OEO grant required that of all the families enrolled:

--At least 50 percent meet Medicaid income eligibility criteria.

--No more than 25 percent have family incomes between the maximum under Medicaid and twice the OEO poverty index. (Premiums were to be paid partially by OEO.)

--No more than 25 percent have family incomes greater than twice the OEO poverty index. (Premiums must be paid by the family or the employer.)[1]

Marketing of the RHN plan was done by Blue Cross/Blue Shield simultaneously with the marketing of two other prepaid health plans--a Blue Cross/Blue Shield-sponsored HMO plan and a prepaid plan of the RHN-affiliated medical foundation. The marketing strategy did not feature open enrollment but was concentrated on employee groups at 21 employers having about 54,000 workers. The results of the initial marketing of the three plans and their capitation rates were:

HMO plan	Number of enrollment contracts	Number of enrollees	Monthly capitation rates (note a) Individual	Family
Medical foundation	523	1,493	$20.02	$60.10
Rochester Blues	338	881	17.42	49.68
RHN	189	493	19.47	56.54
Total	1,050	2,867		

[a]Premiums for the health insurance plan at the largest employer (47,000 employees) were $12.73 for an individual and $34.56 for a family. About 1 percent of the employees changed to one of the HMO plans.

[1]According to an HEW official, under its grant program effective April 1974, HEW had dropped the OEO quota system.

The ability of the RHN to sell its plan was hampered because it was competing with the two other developing HMOs in the Rochester area. As of October 1974, RHN had about 2,700 enrollees, all full paying, whereas the plans sponsored by the Medical foundation and the Rochester Blues had about 11,000 and 9,500 enrollees, respectively. Officials at two of the RHN health centers said that to have a successful HMO operation the stigma that the neighborhood health centers were for poor people would have to be eliminated.

Hunter Foundation--OEO-initiated CHN

The Hunter Foundation for Health Care, Inc., in Lexington was awarded a $1.8 million OEO-CHN grant in June 1971 to develop a health system network for low-income families in Fayette County, Kentucky, and eventually in the 16 surrounding counties. A secondary objective was to provide health related jobs and training for the poor.

The grant was for July 1971 through June 1973. The network was to start providing primary health care by September 1972. Beginning in March 1973, comprehensive health services were to be supplied on a prepaid capitation basis.

Although the September 1972 operating date was not met, health services were provided on a prepaid basis on March 1, 1973. Later that month, OEO awarded a continuation grant of about $1.6 million to cover operating losses for July 1973 through June 1974.[1] The foundation planned to have two health centers with about 18,000 enrollees by June 1974 and to reach its break-even point of 40,000 by June 1976.

In June 1973 the foundation had 94 employees, 30 of whom worked in network administrative areas. The remaining 64, including 1 physician and 1 dentist, were employed at a health center. In August 1973--after being operational 5 months--the foundation had 1,561 enrollees in its medical program.[2] Primary care was provided in a neighborhood health center near downtown Lexington in a building leased from Fayette County at $1 a year. About $167,000 in OEO grant funds was spent to renovate the building.

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[1] HEW has re-funded this project through June 1975 for $1.5 million.

[2] The foundation also had a subsidiary dental program with 508 enrollees.

At the time of our fieldwork, the foundation (1) had agreements with two hospitals to provide inpatient hospital care on a per diem or itemized charge basis, (2) had fee-for-service arrangements with several physician specialists and a University of Kentucky physician group, and (3) was negotiating agreements with a skilled nursing home and a clinic with about 45 physician specialists.

The foundation offered a comprehensive benefit package, including prescription drugs, health education, and social services at basic capitation rates of $16 a month for individuals and $50 a month for a family of four or more. However, the actual amounts to be paid by the enrollees varied from 10 percent to 100 percent of the rates, depending on the enrollee's income and other factors.

Numerous problems have adversely affected this project's development.

Inadequate marketing program

The foundation started providing services on March 1, 1973, and by March 23, 1973, had 400 enrollees in its medical program. In August and December 1973 there were 1,561 and 2,562 enrollees, respectively, compared to projected enrollments of 9,000 and 10,000 for these dates.[1]

Marketing consisted of door-to-door canvassing on a part-time basis by the foundation's clinical staff. Foundation officials said this approach was ineffective because the clinical personnel had other responsibilities and were not fully committed to marketing efforts.

As of August 1973, the only groups enrolled were the foundation's own employees and 1 group of 16 people. The enrollment of groups has been hampered because:

--Kentucky Blue Cross contracts with employers contain a clause voiding Blue Cross coverage if the employer contracts with other hospitalization plans. This

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[1] By October 1974 the foundation had about 4,660 enrollees on a prepaid basis as compared with the projected enrollment of 18,000 by June 1974.

restriction made it difficult for the foundation to offer its HMO plan as an option to employee groups.[1]

--The foundation could not provide statewide or even regional coverage within its own HMO network as desired by some employers.

--Labor unions negotiated health insurance contracts for 2- to 5-year periods and would not discuss changes until the current contracts were ready to expire.

--Potential enrollees felt that the foundation health plan was for poor people because it was funded by OEO.

--The foundation's benefit package did not give the enrollee the freedom to choose his own physician.

As approved by OEO, 50 percent of the enrollees were to meet the OEO poverty guidelines (nominal pay), 25 percent were to be partial pay, and 25 percent were to be full pay.[2]

Although the quota was aimed at the poor and medically indigent, as of August 1973, the foundation had not contracted with the Kentucky Medicaid program to provide services to Medicaid beneficiaries on either a capitation or fee-for-service basis. According to foundation and State officials, the problems involved the following issues:

--Kentucky State law was silent regarding the prepayment of health care under Medicaid, and legal counsel in the State Department of Health advised that this could mean that it was unauthorized.

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[1]Section 1310 of title XIII of the Public Health Service Act (Public Law 93-222), which requires employers to offer the HMO option under certain circumstances, could resolve this problem if the foundation could qualify under section 1310. In commenting on a draft of this report in June 1975, the foundation said that the Blue Cross restrictive clause had been eliminated.

[2]Under the HEW grant, effective in July 1974, the OEO enrollment quota requirements were dropped and as of October 1974, the foundation's 4,660 enrollees were 36 percent nominal pay, 31 percent partial pay, and 33 percent full pay.

--Medicaid providers must be licensed. The regulation for licensing HMOs required the approval of the State Department of Insurance. The department considered HMOs to be nonprofit hospitalization plans which, under the law, must post at least $50,000 in guaranteed fund deposits with the State to protect the insured. The foundation disagreed and refused to deposit the $50,000.[1]

We were told that as of October 1974, the foundation did not have a prepaid Medicaid contract but was providing services to Medicaid recipients on a fee-for-service basis.

The foundation's marketing strategy caused a problem. Initially, advertisements were put on the radio and in the newspapers, and posters were placed in supermarkets. The County Medical Society--whose members comprised one-sixth of the foundation's board of directors--considered this unethical. The mass media advertising was discontinued in February 1973, but the foundation's executive director--who was also a medical doctor--was charged by the society with unethical advertising.

Because the executive director's differences with the medical society were adversely affecting efforts to make arrangements with hospitals and specialty physicians for patient referrals, he resigned effective July 1973.

Organization and staffing

The foundation was governed by a 36-member board of directors consisting of 12 provider members (6 from the University of Kentucky Medical School and 6 from the Fayette County Medical Society), 12 consumer representatives, and 12 at-large representatives. Differences among the members and between the board and the executive director on policy and personnel matters contributed to low staff morale and lack of direction.

The former executive director believed organizational and staffing problems were the largest obstacles to developing the CHN in the HMO model. He said progress was further hampered by the staff's lack of knowledge about the

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[1]In commenting on a draft of this report in June 1975, the foundation said that the State of Kentucky has passed HMO-enabling legislation and the State is reviewing the foundation's technical and financial qualifications. The foundation added that it has deposited $140,000 to meet the requirements of the State HMO law.

business and marketing aspects of providing comprehensive health care services.

Lack of financial stability

The foundation did not have financial stability because it did not have reinsurance for services provided outside the CHN's service area and catastrophic coverage or outside financial support, other than from HEW.[1]

The foundation tried unsuccessfully to obtain reinsurance for out-of-area coverage and catastrophic illnesses from Kentucky Blue Cross/Blue Shield. Except for a limitation on out-of-area coverage of $10,000 per member, the exclusion of organ transplants and chronic renal dialysis, and limitations on psychiatric care, the benefits under the foundation's plan were virtually unlimited. Officials were aware of the financial impact if some members required extended hospitalization or major surgery.

The foundation's principal source of funds was the OEO grant which, for the year ended June 30, 1974, represented about 55 percent of its estimated costs. The remaining costs were to be financed through enrollee capitation payments. Although HEW has eliminated the OEO enrollee quota requirements for its grant supporting the CHN, it appears that, on the basis of the foundation's initial break-even estimate of 40,000 enrollees and the fact that two-thirds of the 4,660 enrollees in October 1974 were either nominal or partial pay, the foundation will require a Federal or other financial subsidy for the foreseeable future.

In commenting on a draft of this report in June 1975, foundation officials advised us that

--it had a full-time marketing staff;

--enrollment had increased to 5,518, including 685 members representing 32 groups; and

--it had negotiated a catastrophic reinsurance arrangememt limiting the foundation's expenses to 10 percent of the costs in excess of $15,000 per member per illness with the reinsurer's liability limited to $250,000 per member per illness.

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[1]As noted on p. 6, HEW assumed responsibility for administering the OEO-initiated CHN grant projects in July 1973.

Regarding the latter point, Public Law 93-222 authorizes HMOs to have reinsurance for the costs of health services in excess of $5,000 per member per year. Under the foundation's reinsurance arrangement, if only one percent of its members incurred the maximum uninsured cost of $15,000, this would represent about $825,000--or over twice the total capitation payments the foundation expects to receive in fiscal year 1975.

Penobscot Bay Medical Center--
OEO-and HEW-funded rural project

This center consists of an ambulatory care unit in Rockland, Maine--next to the 87-bed Knox County General Hospital--and administrative offices in the adjacent town of Rockport, Maine.

The center's primary objective has been to develop a comprehensive health care system, including a new $9 million 106-bed hospital to replace the county hospital. Construction began in July 1973 on land donated by private industry, and completion was scheduled for sometime in 1975. Construction was financed with community contributions of about $3.5 million, the help of a Hill-Burton grant, and a non-Federal loan guaranteed by the Hill-Burton program, which will also subsidize the interest payments.

The center received three grants from OEO totaling about $1.9 million for July 1970 through June 1974 to:

--Plan, construct, and operate the ambulatory care unit.

--Develop a comprehensive prepaid health care system to serve the poor as well as the near-poor and nonpoor residents of the midcoast region of Maine.

The center also received the following funds from HEW:

--A $54,000 grant from the Social and Rehabilitation Service (SRS) for July 1971 through November 1972 to develop a system to include Medicaid recipients in its program.

--A $107,000 contract from HSA for June 1971 to June 1974 to assist potential HMOs in the Rockland area. The contract was later changed to allow the center to develop its own HMO. (See p. 58.)

Operations at the ambulatory care unit began in July 1972. By June 30, 1973, the center had 1,406 enrollees, consisting of 302 families and 105 single individuals, as compared with the projected enrollment of 2,000 persons by that

date.[1] All enrollees were required to meet OEO income criteria--limits ranging from $2,100 for an individual to $6,200 for a family of seven or more--and their capitation rates were paid with OEO grant funds. Of the 1,406 enrollees, 33, or about 2 percent, were also eligible for Medicare and 55, or about 4 percent, were eligible for Medicaid.

One of the conditions of the OEO grants was that the center was to diligently negotiate a prepaid capitation contract with the State Medicaid agency.

The SRS grant's purpose was to develop a system for including Medicaid recipients in the program. In January 1973 the center began to enroll both Medicare and Medicaid recipients, but only if they met OEO income criteria. These enrollees were charged the same capitation rates as the OEO enrollees, and the rates were paid with OEO grant funds.

As of August 1973, the center had not developed a separate benefit package or capitation rates for a Medicaid contract and had not contracted with the State agency to cover Medicaid recipients on a prepaid basis. Although a TAP contractor for the HEW region developed capitation rates, they were not used.

The TAP contractor was requested to develop a capitation rate for Medicaid recipients to be used in a proposal to the State of Maine. The TAP contractor, whose work was performed between September and November 1972 at an estimated cost of $13,900, developed three capitation rates:

1. A rate based on the average cost per Medicaid recipient in Maine.

2. A rate based on the estimated average cost per Medicaid recipient in the center's service area.

3. A rate based on utilization experience of similar prepaid Medicaid and OEO programs combined with the center's operating costs.

According to the TAP contractor's February 1973 report to the center, its research indicated that Medicaid recipients in the center's service area were less of a risk than

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[1] At December 31, 1973, the center had 1,833 enrollees, all of whom were required to meet OEO income criteria. HSA reported in October 1974 that the enrollment had increased to 2,200, and in commenting on a draft of this report in June 1975, the center said the enrollment was 2,400.

in the entire State. The contractor recommended that either item 2 or 3 be used.

However, the center did not use any of the capitation rates and did not submit a formal proposal to the State Medicaid agency. The center's associate director said the center did not accept the recommended rates because it believed the Medicaid population contained too many bad risks and there would not be a sufficient number of enrollees over which to spread the risks.

An official of the State Medicaid agency told us that the State was willing to negotiate a prepaid contract but had not received a formal proposal from the center.

The associate director of the center said its lack of progress in obtaining a Medicaid contract was due to physician opposition. He said the physicians feared a loss of income if the center was to serve Medicaid recipients.

Although the center was providing services to enrollees as called for in the OEO grant, we do not believe it achieved the objectives of the SRS grant. (See ch. 5.)

Geisinger Medical Center--HEW funded

This center, located in a semirural community in north central Pennsylvania, has been providing medical services since 1915. In January 1972 HEW awarded Geisinger a $126,000 grant to develop a comprehensive prepaid health care program. Geisinger officials said they wanted to start an experimental HMO:

--To see if it would improve the health care delivery system in the area by reducing medical costs and improving services.

--To see if Geisinger would support both a prepaid and fee-for-service operation.

--To be prepared if national health insurance became a reality and the Federal Government began to push the HMO concept.

Although more comprehensive, Geisinger's family benefit package costs about $16 a month more than the most expensive Blue Cross package in the area.

Marketing of Geisinger's prepaid plan began in May 1972 and the first enrollees joined the HMO in July 1972. HEW

considered Geisinger an operational HMO in July 1972, although only three persons were enrolled at the end of that month. The HMO began delivering services in September 1972 with 333 enrollees. As of October 31, 1974, the HMO had 1,611 enrollees, of which 1,349 (83 percent) were its own employees and their dependents.

Marketing of the plan was done by Blue Cross, which had estimated that, based on a 5-percent market penetration at employer groups, Geisinger would have an initial enrollment of 1,125. Geisinger established a maximum enrollment objective of 5,000, at which point it planned to evaluate the progress and future potential of the HMO. However, Geisinger officials had no idea when this enrollment would be reached or whether it would be enough to enable the HMO to break even.

Geisinger planned to serve HMO subscribers in a 1,715-square mile, 5-county area with a population of about 229,000. However, initial marketing efforts were concentrated in 1 county and 2 small communities in another--a combined population of about 22,000.

Blue Cross has generally limited its marketing efforts to employer groups in the area, although a 2-week open enrollment period was held in February 1973. This produced only 56 enrollees, despite local radio and newspaper advertising and the blanket mailing of literature to area residents. Although Geisinger had made only one sales approach to its own employees[1]--in the form of a letter inserted in pay envelopes in September 1972--about 33 percent of Geisinger's employees have enrolled in the plan.

In May 1972 HEW recognized that marketing the plan would be a major problem. After a site visit, HSA headquarters and regional office officials stated that Geisinger did not have a well-planned marketing strategy, but was relying on Blue Cross and Geisinger's reputation for delivering health care. The HEW officials pointed out that (1) the monthly family capitation rate appeared high for the area (2) Geisinger was not familiar with the marketing techniques needed to sell a prepaid health plan, and (3) the approach of the Blue Cross salesmen in selling an HMO plan needed analysis and improvement.

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[1]In addition to the one time sales approach, Geisinger offers the HMO option to all new full-time employees after they complete a 6-month probationary period.

In May 1973 the TAP contractor for the region advised the HEW regional office that the Blue Cross marketing performance had been extremely unsatisfactory. The contractor stated that Blue Cross had not tried hard enough and that, even if it worked hard, it did not have the background and understanding to sell the HMO concept. The contractor's report to Geisinger made several recommendations to improve the marketing. When we completed our fieldwork, Geisinger officials said the recommendations were still being studied.

In addition, Geisinger had problems recruiting physicians. Originally, the HMO was staffed with three full-time general practitioners, but two left for other positions. As a result, Geisinger was forced to (1) temporarily close a satellite facility, which provided ambulatory services to residents in an outlying community, and (2) use its own staff physicians and specialists to provide primary care. Recruiting efforts for permanent HMO physicians have been unsuccessful but were continuing. Geisinger officials believed the difficulty lay in convincing general practitioners to give up their fee-for-service practices to participate in the new HMO concept.[1]

CMA-HMO, Inc.--HEW funded

CMA-HMO, Inc.,[2] was organized in August 1971 to develop a health care delivery system in the Chicago metropolitan area that would give consumers a choice between prepayment and fee for service. In January 1972 HEW awarded CMA-HMO a $98,840 grant for 1972 to develop an HMO. Another grant for $125,000 to continue development of the HMO was awarded for 1973, and a continuation grant of $75,000 was made to fund the project through June 1974. The HMO planned to enroll only Medicaid recipients for the first 6 months of operation and hoped to be operational in January 1973.

After the initial marketing period to Medicaid eligibles, the HMO planned to market to employer groups through commercial insurance companies. The companies were to offer the HMO plan in addition to their own health insurance.

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[1] In commenting on a draft of this report in June 1975, Geisinger told us it had recruited two family practitioners.

[2] In December 1973 the plan's charter was amended to change the name to CURE Health Plan, Inc.

The area to be served by the project overlapped the area to be served by an OEO-initiated CHN, and both projects were planning to market initially to Medicaid recipients. (See p. 83.)

Although contracts had not been executed at the time of our fieldwork, the HMO had arranged for access to clinical facilities, had arranged for the services of a physicians' group then operating on a fee-for-service basis, and had drafted contracts with other providers. However, its progress in becoming operational was basically contingent on executing a prepaid Medicaid contract. According to a plan official, the medical group affiliated with the HMO was serving 10,000 to 12,000 people, of which 70 percent were Medicaid eligibles. Thus, if the project were to enroll those Medicaid eligibles being serviced by the physicians' group, the HMO project could have an early enrollment of 7,000 to 8,000 people. This official estimated that, if the Medicaid contract was signed, the project would have 2,000 Medicaid enrollees in the first month of operations.

As of December 31, 1973, or a year after its planned operational date, the project did not have a Medicaid contract nor was it operational.

The project had attempted to contract with the Illinois State Medicaid agency since the summer of 1972. At that time, a State official indicated that the project's proposal was acceptable and there would be no problems in signing a contract in 3 weeks. However, the contract was not signed and in November 1972, a new State administration was elected.

According to the HMO's president and State officials, the State developed new guidelines for HMO contracts for Medicaid recipients. They were issued in November 1973 because the new administration did not want to be committed to a program established by the prior administration and wanted to set higher standards of medical care for Medicaid recipients.

However, both versions of the State guidelines provided that not more than 50 percent of the plan's enrollees could be Medicaid and Medicare recipients unless justifications were approved by the State and agreed to by HEW.

On July 31, 1974, CURE entered into a Medicaid contract--subject to HEW approval--to provide services to Medicaid recipients eligible under the Aid to Families With Dependent Children program. However, because this project was initially designed to enroll only Medicaid eligibles, one condition for HEW's approval was the waiver of the pro-

vision in State and Federal guidelines limiting Medicare and Medicaid recipients to no more than 50 percent of the total enrollment.

In September 1974, HEW approved the Medicaid contract and in October 1974--or almost 2 years after its planned operational date--CURE was operational with 2,000 enrollees--all Medicaid eligibles.[1]

LESSONS LEARNED UNDER PRIOR PROGRAMS

Although the projects initiated by OEO were designed to serve the poor and near-poor, a major factor inhibiting their development on a prepaid basis was the lack of access to the Medicaid enrollee market.

The apparent anomaly of the OEO-initiated and HEW-supported CHNs' inability or unwillingness to negotiate agreements on a prepaid basis with the HEW-supported Medicaid program should be a matter of concern to HEW and the Congress, because it evidences the lack of effective coordination between the two programs designed to benefit many of the same people.

In January 1974 HEW issued regulations applicable to projects financed under section 314(e) of the Public Health Service Act--including CHNs--aimed at encouraging such projects to obtain maximum reimbursement for services from federally supported third party payment programs. Further, title V of Public Law 94-63, enacted July 29, 1975, repealed section 314(e) and added a new section 330 to the Public Health Service Act providing for community health centers--which included CHNs. This new section provided that except for projects which provide health services to medically underserved populations, HEW may not approve a grant unless HEW determines that:

--The center has or will have a contractual or other arrangement with a State Medicaid agency for the payment for services provided to eligible persons.

--The center has made or will make every reasonable effort to enter into such an agreement.

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[1]In commenting on a draft of this report in June 1975, CURE officials said that the current enrollment was about 10,000--all Medicaid eligibles.

However, neither the HEW regulations nor the new act would require such reimbursement to be on a prepaid basis, which was how the CHNs were intended to operate.

While we found no easy solutions to the problems encountered by the developing HMOs reviewed under HEW's earlier program, we believe the following two situations should be avoided in awarding grants, contracts, or loan guarantees for the planning and initial development of HMOs under Public Law 93-222.

Initial marketing strategy geared principally to Medicaid recipients

Public Law 93-222 requires HMOs to enroll persons broadly representative of the various age, social, and income groups within the area to be served. An exception to this is that in areas with a medically underserved population, which receives priority in funding, no more than 75 percent may be enrolled from such an underserved population unless the area is also a rural area.

To meet this objective, we believe that an initial marketing strategy geared solely or principally to Medicaid recipients should be avoided.

An important factor inhibiting the progress of HEW's pre-Public Law 93-222 HMO development program was the overreliance on the States' Medicaid programs as the primary source of enrollees and financial support. Often, the operational status of a project was contingent on obtaining a Medicaid contract. Four of the ten HEW projects included in this chapter had an initial marketing strategy geared solely or principally to Medicaid recipients with enrollments planned to be expanded later to other groups. One project, which became operational in July 1972, did enroll a substantial number of Medicaid eligibles only, but reported it had experienced heavy operating losses during its first year of operation. The other three Medicaid-oriented HMOs did not become operational until 1974, or from about 6 months to 2 years after their scheduled operational dates, because of

difficulties and related delays in negotiating prepaid contracts with the State Medicaid agencies.[1]

Although HEW has consistently supported the participation of HMOs in the Medicaid program, and one State program in particular (California) provided impetus to the movement toward prepaid health care, significant obstacles arose to the development of Medicaid-only HMOs. For example, July 1972 guidelines for Medicaid contracts for HMOs in Illinois provided that Medicaid and Medicare enrollments could not make up more than 50 percent of the membership unless justification existed which was approved by the State agency and HEW. Other large States also stressed the desirability of broad based or representative enrollment as a condition for Medicaid contracts.

The Senate version of the Social Security Amendments of 1973 (H.R. 3153) which passed the Senate on November 30, 1973, but which was not enacted into law, prescribed certain conditions and standards for HMOs participating in Medicaid. Included was a provision that, to qualify for capitation payments under Medicaid, the HMO needed a minimum enrollment of 5,000, at least half of whom were not to be Medicare or Medicaid recipients.

In June 1974 HEW issued proposed Medicaid regulations, pertaining to contracts with HMOs, which require an HMO to serve a population broadly representative of the various age, social, and income groups within the area it serves. An exception to this is that within 2 years after the effective date of the Medicaid contract, no more than 50 percent of the enrolled members may be Medicare or Medicaid recipients.

Finally, October 1974 HEW regulations implementing Public Law 93-222 provided that at no time shall Medicare and Medicaid members of a qualified HMO constitute more than 50

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[1] HEW regulations pertaining to applications for financial assistance for initial development under Public Law 93-222 provide that an applicant which intends to serve Medicaid eligibles as part of the intended enrollment must provide evidence, in the form of a letter or other document from the State Medicaid agency, that the agency is willing to negotiate a prepaid capitation contract. On the other hand, similar guidelines for the earlier program required data on the development of an effective marketing plan, with emphasis on specific contractual arrangements, if marketing to Medicaid eligibles was to be part of the effort.

percent of the total membership, unless for good cause, the Secretary waives this requirement.

Aside from the delays and related uncertainties experienced by many HEW-funded HMO projects by taking the Medicaid-only approach as a basis for becoming operational, there is some evidence that HMOs initially aimed at principally serving the poor may have difficulty in marketing their plans to other groups. For example, officials of two of the operating CHNs reviewed said their marketing efforts were hampered by the stigma that their health plans were for poor people. Further, neither of the two OEO-HEW-funded operational rural prepaid projects nor three of the four HEW-funded operational HMOs reviewed, which were initially aimed at serving the poor, had demonstrated an ability to market their plans to other groups.

Funding competing HMOs in the same area

Section 1310 of the Public Health Services Act, as enacted by Public Law 93-222, requires employers offering health benefit plans to employees to include the option of membership in each of two types of HMOs, provided such organizations are serving in the area in which such employees reside. The two types of HMOs are (1) those providing service through health professionals who are members of the HMO staff or of a medical group or groups and (2) those providing services through health professionals participating in individual practice associations (the foundation type). Thus, the Congress did not give a preference or advantage to either existing foundation-HMOs or to existing group-practice HMOs.

On the other hand, the difficulties experienced in marketing the developing HMOs reviewed suggests to us an underlying initial consumer resistance to the HMO concept--at least until it becomes well-established and accepted in the community.

One condition which probably inhibited project development under the prior OEO and HEW programs was the presence of two or more federally funded developmental or operational projects competing for some of the same markets, such as in Rochester.

Therefore, in view of the initial underenrollment problems experienced by virtually all the projects reviewed, we question the wisdom of simultaneously providing financial support to two or more developing HMOs which will be competing in the same areas for the same markets and where the HMO concept is not already well-established in the community. Developing HMOs will have enough problems in becoming self-sustaining and will encounter sufficient competition from the traditional fee-for-service delivery system in such areas without competing with one another in the initial development stage.

CONCLUSIONS

The ability of the CHNs and the rural OEO projects reviewed to develop and market a comprehensive prepaid benefit package either to the poor or to other groups has not been impressive. Although HEW's action in eliminating the OEO-enrollee quota requirements could facilitate the development of these projects, the feasibility of the initial CHN approach as an HMO prototype for the poor or near-poor--as contrasted to providing access to primary ambulatory care in the CHN health centers--should be reexamined in light of the lack of progress in meeting the existing objective for an HMO. HEW needs to evaluate and perhaps redefine the objectives of these projects.

The problems experienced by most of the HEW-funded projects reviewed, which had started operations in 1972 and 1973, centered around underenrollments. The most common problems facing those projects becoming operational in 1974 were also underenrollment and the delays and uncertainties resulting from the overreliance on State Medicaid programs as the primary source of support for becoming operational. Despite the evidence that some States, the Congress, and HEW did not want Medicaid-only HMOs, the HEW-funded projects were committed to and persisted in pursuing this strategy.

RECOMMENDATIONS TO THE SECRETARY OF HEW

We recommend that HEW reexamine the feasibility of the CHN approach as an HMO in light of the lack of progress in meeting the HMO objectives and consider redefining the objectives of such projects.

We also recommend that, in considering grants, contracts, or loan guarantees for the planning and initial development of HMOs under Public Law 93-222, HEW avoid

--situations when the project's initial marketing strategy is geared solely or principally to Medicaid recipients and

--simultaneously funding the development of two or more competing HMOs in the same area where the HMO concept is not already accepted by the community.

AGENCY COMMENTS AND OUR EVALUATION

HEW said that it was reexamining the feasibility of the CHN concept. They stated that specific program indicators are being developed for CHNs, and projects unable to comply with these indicators will be assessed to determine if there is a continued need for Federal funds to support ambulatory care services within their communities. HEW stated that the ambulatory patient care (APC) project in Ohio and the Penobscot Bay project in Maine were currently being reexamined and all similar projects will be examined during fiscal year 1976.

Concerning our recommendation that HEW try to avoid situations where the projects' initial marketing strategy is geared solely or principally to Medicaid recipients, HEW agreed that, to the extent possible, it should not fund organizations which intend to market principally to Medicaid recipients. They pointed out, however, that the only urban populations which qualify as medically underserved, and thus eligible for priority funding, are those which are heavily supported by Medicaid. Although projects serving these areas must provide acceptable plans for enrolling employed persons, HEW stated it is difficult to assess the validity of such plans because of the problems which have been observed in enrolling employed persons in what is concluded by outsiders to be a "poor people's" HMO. HEW added that it urges such projects to initiate private enrollments first, but concluded that because of the need for health care in these areas and the statutory priority for medically underserved areas, it does not appear possible for HEW to deny a well-documented application.

We believe that HEW's comments recognize the problems encountered in the prior programs by placing too much reliance on the Medicaid program as the primary source of enrollees and financial support.

HEW did not agree with our recommendation that it avoid funding, in all cases, the development of competing HMOs in the same area where the HMO concept was not already accepted by the community. HEW said that there are several factors

which must be considered before determining whether to fund more than one HMO in an area including

--the size of the population;

--the income level;

--the types of proposed organizations, i.e., group practice or individual practices; and

--the level of funding, i.e., feasibility, planning, or initial development.

HEW stated that it did not intend to give an exclusive franchise to any organization where there is evidence that an area can support more than one HMO.

We recognize there are several factors that have a bearing on whether more than one HMO can become a self-sustaining entity in a particular geographic area. We are not recommending that HEW support only one HMO in any area. However, the marketing difficulties encountered by the developing HMO-type organizations we reviewed indicates there is an initial consumer resistance to the HMO concept. We believe that HEW should not simultaneously provide financial support to two or more HMOs which will be competing in the same area for the same market. In our opinion, it would be more appropriate to provide financial support to a second developing HMO after one HMO had successfully demonstrated its acceptance in a community.

CHAPTER 5

EXPIRED OR POTENTIALLY UNSUCCESSFUL CONTRACTS AND GRANTS

Eighteen[1] of the thirty-eight organizations reviewed had grants or contracts which had expired, had been terminated, or, at the time of our fieldwork, appeared to have little prospects of producing useful results. All but one of these were HEW-initiated projects and included:

--1 OEO-initiated CHN that had spent about $700,000 of its $2,071,822 in planning and development grants.

--3 generator contracts (organized to help others develop HMOs) which received awards totaling $1,054,901.

--13 organizations whose HEW grants had expired or had been terminated. Initial grants to these organizations totaled $1,021,150, and five had received continuation grants totaling $695,971.

--1 organization whose experimental health services contract of $1,225,000 included $525,000 to develop an HMO.

The OEO-initiated CHN never became operational on a fee-for-service or prepaid basis, and in June 1974 HEW disapproved the CHN's request for continuation funding because of the lack of progress in meeting grant objectives.

The HEW generator contractors were generally unsuccessful in helping other organizations develop HMOs. Two of the contractors tried unsuccessfully to develop HMOs themselves, rather than assisting other organizations, while the third assisted six organizations. At the time of our fieldwork, three had become operational, but the generator contractor's assistance to these was minimal.

The 13 HEW grantees that were to develop HMOs could not reach such basic goals as (1) developing benefit packages, capitation rates, and marketing strategies and (2) enlisting provider and community support. Two of the thirteen projects were designed to be initially Medicaid-only HMOs, and for various reasons, the prepaid contracts with the State agencies

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[1] Includes the Penobscot Bay Medical Center discussed in chapter 4, which also received a grant from SRS which had expired.

did not materialize. The HEW grants for one project were to develop an HMO with representative enrollment, but it became operational as a Medicaid-only experimental project with automatic rather than voluntary enrollment.

The recipient of the experimental health services delivery system contract had made little progress in 27 months (June 1971 to Sept. 1973), and, rather than developing an HMO itself, was seeking to assist others to develop them before the contract objectives were revised in June 1974. (See p. 99.)

The 18 projects are listed in appendix II. More detailed information on some of the projects, based principally on data obtained during our visits, including interviews with grantee officials, follow.

OEO-INITIATED CHN

Of the seven urban CHNs reviewed, one was terminated by HEW after our fieldwork.

First Maryland Health Care Corporation

The corporation was formed in March 1971 to develop a community health network in west and northwest Baltimore. Under an OEO planning grant of $98,880--from July 1, 1971, to June 30, 1972--First Maryland prepared a proposal to develop a network consisting of five HMOs, each of which would offer a common benefit package developed by the grantee. Two of the planned HMOs were providing medical services, and First Maryland planned to develop the remaining three. First Maryland planned to contract for medical services with the five HMOs which, in turn, would be responsible for hiring or contracting with physicians.

In June 1972 OEO awarded First Maryland a $2 million grant for July 1, 1972, through June 30, 1974, to develop the CHN. Under the grant terms, the three HMOs to be developed by First Maryland were to start providing services in accordance with the following timetable.

Organization	Planned operational dates	
	Fee for service	Prepaid
Northwest Baltimore Corporation	Apr. 1, 1973	Oct. 1, 1973
Workers Allied Toward Community Unity	July 1, 1973	Jan. 1, 1974
Lower Park Heights Coordinating Council	July 1, 1973	Jan. 1, 1974

In addition, the grant required First Maryland to:

--Begin purchasing prepaid medical services from the West Baltimore Community Health Care Corporation and the Monumental Medical Association starting July 1, 1973.

--Negotiate a prepaid Medicaid contract with the State of Maryland.

As of December 31, 1973--18 months after the grant was awarded--none of the three centers which First Maryland planned to develop had become operational. Moreover, the grantee had not negotiated contracts for providing medical services with the remaining two centers and had been unable to obtain a prepaid Medicaid contract with the State of Maryland.

Problems encountered by First Maryland in attempting to develop the network are discussed in the following paragraphs.

Development of ambulatory care facilities

As previously mentioned, First Maryland planned to form a network involving five organizations for west and northwest Baltimore. However, after analyzing demographic and marketing statistics on residents of northwest Baltimore (the area to be served by the Lower Park Heights Coordinating Council and the Northwest Baltimore Corporation) and west Baltimore (the area to be served by the Workers Allied Toward Community Unity and the West Baltimore Community Health Care Corporation), First Maryland concluded that each area could support only one center.

Much of First Maryland's time was spent in trying to convince the four community organizations to merge into two organizations. A merger between West Baltimore Community Health Care Corporation and Workers Allied Toward Community Unity was agreed to in April 1973, but was not finalized until August 1973. Merger negotiations between Northwest Baltimore Corporation and Lower Park Heights Coordinating Council were still continuing in April 1974.

Delays in obtaining facilities have also hampered the development of the network. Although First Maryland concluded that only one center was feasible in west Baltimore, it planned to provide ambulatory care at two locations. One of these locations was being used by West Baltimore Community Health Care Corporation to provide health services to Medicaid recipients. The other facility was to be renovated by Workers Allied Toward Community Unity under a grant from

the Department of Housing and Urban Development. First Maryland's grant proposal stated that renovation of this facility was underway and was expected to be completed by January 1973. However, renovation did not start until December 1973, primarily because of a dispute between the city of Baltimore, the Department of Housing and Urban Development, and the Department of Labor over the wage rates to be paid.

With respect to a facility for the northwest Baltimore area, First Maryland participated in feasibility studies and/or surveys of 10 sites, but had not selected a site as of April 1974. According to First Maryland's executive director, the community organizations could not agree on a site.

Provider agreements

First Maryland made little progress toward obtaining agreements with physicians and hospitals. The grantee had planned to contract with the individual HMOs which, in turn, would hire or contract with physicians. Because of the problems in trying to get four organizations to merge into two and the delay in obtaining facilities, the individual HMOs made little attempt to obtain agreements with physicians.

First Maryland stated that, in addition to developing three HMOs, it planned to purchase medical services for "OEO poor" enrollees from two existing organizations (the Monumental Medical Association, an independent group practice, and the West Baltimore Community Health Care Corporation, a community organization) at a monthly rate of $19.39. However, as of December 31, 1973, First Maryland had not negotiated a contract with either organization. According to First Maryland's executive director, the grantee had been unable to reach agreement on the rate and quality assurance provisions.

Benefit package, capitation rates, and marketing strategy

First Maryland planned to develop a common benefit package that would be offered at all the delivery sites in the network. The grantee planned to use its own marketing representatives to market the plan to the OEO poor and Medicaid recipients and contract with Maryland Blue Cross to market the plan to the private sector.

First Maryland drafted a benefit package, and by April 1974 the following monthly capitation rates had been developed:

Individual	$20.91
Parent and child	41.82
Family	67.02

The actual amount to be paid by public sector enrollees would vary depending on income and family size.

The executive director told us that First Maryland planned to offer the same benefit package to both public and private sector enrollees. However, in July 1974, Blue Cross advised First Maryland that much remained to be done before Blue Cross would market the plan. Specifically, Blue Cross required:

--Assurances that the network providers were committed to First Maryland's efforts and had the capability to deliver health care.

--Contractual agreements between Blue Cross, the providers, and First Maryland.

--Assurances that First Maryland would receive continued Federal financial support for administrative costs.

Medicaid contract

Although the OEO grant required First Maryland to negotiate a prepaid Medicaid contract with the State of Maryland, the grantee never obtained it. Shortly after the development grant was awarded in June 1972, the State decided to discontinue awarding capitated Medicaid contracts. A State Medicaid official told us in July 1973 that, before the State would award more capitated Medicaid contracts, HEW needed to (1) develop guidelines on the number of enrollees for each contract, (2) develop guidelines on the type of coverage and service, (3) decide whether to have open enrollment, and (4) decide whether to lock in members to a single plan.

Staffing problems

Staffing problems hindered network development. Since its inception in March 1971, First Maryland had three executive directors and one acting executive director. In addition, the grantee encountered difficulty in hiring persons experienced in the health field.

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In summary, First Maryland had accomplished virtually none of the objectives in its $2 million development grant,

and in June 1974 HEW terminated the project effective October 31, 1974. Unexpended grant funds of about $1.4 million reverted to the Federal Government.

HEW GENERATOR CONTRACTS

HEW awarded generator contracts totaling $1,232,401 in initial and continuation funding to four organizations to stimulate and assist others in developing HMOs. We reviewed the following three contracts totaling about $1,055,000.

Contractor	Total contract amount	Period of performance
Genesee Region Health Planning Council, Rochester	$397,901	June 1971 to Dec. 1973
Penobscot Bay Medical Center, Rockport	107,000	June 1971 to June 1974
Maryland Health Maintenance Committee, Baltimore	550,000	June 1971 to Sept. 1973

Two of the three generator contracts reviewed are discussed below.

Genesee Region Health Planning Council

Since 1970, the council in Rochester has been receiving assistance from HEW under section 314 (b) of the Public Health Services Act as a comprehensive health planning agency. The council provides health planning services for the Genesee region, a 10-county area of New York, and 55 percent of its budgeted expenditures have been reimbursed by HEW.

In June 1971 the council received a $250,000 1-year cost reimbursement contract from HEW to provide technical assistance to organizations interested in developing HMOs. The contract required the council to develop information critical to establishing HMOs in the 10-county area. The contract was extended through December 31, 1973, and the contract amount was increased by $147,901 to provide continued assistance to organizations interested in developing HMOs, with emphasis to be placed on the support of organizations previously identified as potential HMOs.

The council originally identified eight (later reduced to six) organizations to help develop HMOs. At the time of our fieldwork, the council had spent about $307,000 of the

contract funds of $397,901. Three of the six organizations assisted had started accepting prepaid enrollees by December 1973, two were still in the planning or developmental stages, and one had failed to develop an HMO because of physician opposition. The three organizations that had developed operational HMOs received only limited assistance from the council.

The council devoted about 70 percent of its professional staff time and paid about $31,000 in consultant fees in support of the two organizations that were still developmental at the time of our fieldwork.

The council's project director for the generator contract stated that the main problems encountered in developing an HMO were

--physician opposition,

--marketing, and

--funding a potential HMO through its planning and development stages.

Funds used to develop competing HMOs in the same area

The three HMOs assisted by the council, which did become operational on a prepaid basis, were competing with one another in Rochester. One of the HMO projects (Genesee Valley Group Health Association) was sponsored by the Rochester Blue Cross/Blue Shield plans and is discussed in chapter 3; the second (Rochester Health Network) was an OEO-initiated CHN and is discussed in chapter 4; and the third project was developed as a foundation-type plan sponsored by the county medical society with some financial assistance from OEO. As noted on page 32, all three projects were initially marketed simultaneously to large employer groups with only limited success.

The council provided minimal assistance to the association, paid about $24,700 in consultant fees, and spent about 1 percent of its professional staff time assisting the CHN. The council paid about $22,000 in consultant fees and used about 4 percent of its professional staff time to assist the foundation.

On December 31, 1973, the generator contract expired.

Penobscot Bay Medical Center

The center received, in addition to the grants discussed on pages 38 to 40, an HEW generator contract for $107,000 to provide technical assistance to potential HMOs in the Rockland, Maine, area. This contract was originally for the 12 months ended June 29, 1972, and was later extended to June 1974 without additional funds.

The contract required the center to assist potential HMOs by developing information on such critical factors as feasibility, legal capacity, resource acquisition, marketing, and financing. But a center official said that it never intended to act as a generator of other HMOs. Such an approach would have been impractical, because only two or three organizations in the State had HMO potential.

The center disclosed its intent to use the contract funds to develop its own HMO in a workplan submitted to HEW in October 1971. Although it did not meet the contract terms, HEW approved the plan as consistent with contract objectives.

Six months later, in April 1972, HEW modified the contract to allow the center to develop an HMO to serve all residents of the midcoast region of Maine. At this time, the center had already received a second OEO grant for $897,321 to develop and operate an HMO prepaid plan to serve the medically needy in the same area.

As of June 30, 1974, the $107,000 contract funds had been spent but little progress had been made toward developing an HMO. A benefit package and related capitation rates were not developed for private sector enrollees, nor were arrangements made with physicians and hospitals to provide services. Most of the funds were used to pay the salaries of professional and administrative staff. The main efforts of the professional staff were directed at meeting the goals of the OEO grants and developing a regional hospital. According to a center official, the development of an HMO to serve a broad range of enrollees was unlikely because of physician opposition.[1]

In June 1974 the contract expired with no material change in the center's progress in the development of an HMO for other than the OEO-eligibles.

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[1]In commenting on a draft of this report in July 1975, the center said that the physician opposition has been overcome and the center's current emphasis is on open enrollment.

EXPIRED OR TERMINATED HEW GRANTS

Thirteen of the organizations reviewed had initial grants totaling $1,021,150, which had expired without an HMO being developed. Five of these organizations had received continuation grants totaling $695,971, which had also expired or been terminated. Seven projects had ended in 1972, three in 1973, and three through June 30, 1974. Project failures were attributed to both internal and external factors.

Of the external factors, the most common involved the reliance on third parties such as Medicaid, insurance carriers, or a developing CHN to provide support for the project to progress. When such support did not materialize or was withdrawn, the project collapsed. The other most common external factor contributing to the failure to develop an HMO was the inability to get physician support. In two cases, this was determined early, and in relation to the objective of establishing the feasibility of an HMO, such a project could be termed a success.

The internal factors involved the lack of strong leadership and policy guidance, the lack of commitment to the HMO concept, and diversion of efforts to activities other than the development of an HMO.

A discussion of three HEW-funded projects which expired or terminated in 1973 follows.

Denver Department of Health and Hospitals

This department, a municipal corporation of the city and county of Denver, received an HEW grant of $80,228 for July 1, 1971, to June 30, 1972, to develop a publicly administered HMO. Four revisions were made to the first grant, and the performance period was ultimately extended to February 28, 1973.

Although the cognizant HSA regional program director opposed continuation funding because the department had not made adequate progress on the first grant, HEW awarded a continuation grant of $121,450 in February 1973 for March 1, 1973, to February 28, 1974. This grant was awarded even though HEW regional and headquarters officials had concluded in November 1972 that there was little likelihood of the department being able to accomplish one of the key elements of an HMO.

In our opinion, the continuation grant should not have been awarded. The HEW regional office initiated action to

terminate the second grant on May 21, 1973, and a termination date of September 30, 1973, was later set. By termination date, the department had spent $95,490 of the $201,678 total grant funds awarded.

HEW awarded the first grant of $80,228 to the department to develop an HMO operated by a public agency. After an initial analysis phase, the grantee was to develop those items necessary for the actual operation of an HMO--benefit package; capitation rates; prepaid agreements and/or contracts; marketing enrollment; and organizational strategies. Although not a condition of the original grant, the issue ultimately arose as to how the department, whose physicians were city civil service employees, could meet the HMO conceptual requirement of placing the physicians at financial risk--providing financial incentives or payments--for the efficient use of health services.

On June 6, 1972, the HEW regional office approved a grant period extension to August 31, 1972, with the condition that the department develop an organizational structure to place the physicians at financial risk. On August 29, 1972, the regional office authorized a further extension of the grant period to February 28, 1973, subject again to the physician-at-risk requirement. The regional office suggested that this be accomplished by the physicians resigning from the city civil service and incorporating and contracting with the HMO to provide services on a lump sum or per capita basis.

Although the department did not develop an organizational structure to place the physicians at risk during the two grant extensions, HSA awarded a continuation grant in February 1973 to "meet the cost of implementing the HMO in a timely fashion." The physician-at-risk requirement was made a condition of the grant. However, at the time of the award, the department had made little or no progress in meeting the basic requirements of an operational HMO, such as developing benefit packages, capitation rates, and marketing plans, and had not resolved the issue of placing the physicians at risk. Moreover, in November 1972--3 months before the award of the continuation grant--HEW regional and headquarters officials had concluded that there appeared to be no meaningful way for the department's physicians to assume financial risk.

In a May 21, 1973, letter, HEW requested the department to show cause why the grant should not be terminated because:

--After almost 2 years of grant expenditures, there had been no discernible progress toward accomplishing the basic steps necessary to organize an HMO.

--The department had not fulfilled grant conditions concerning a commitment to risk sharing and development of a plan to convert the department's patients to capitation as an option to the fee-for-service system.

--The administration of the department did not subscribe to either the program requirement or the concept of risk sharing by the professional providers as a key element of an HMO.

--Several Denver city officials had taken the position that creation of a separate organizational entity outside the city civil service career system to achieve professional risk sharing would be illegal.

On July 10, 1973, the HEW regional health director notified the department officials that formal procedures for terminating the HMO continuation grant had started. The department did not appeal the termination within the prescribed period, and ultimately a termination date of September 30, 1973, was set.

In commenting on a draft of this report in June 1975, the department stated the grant was "to study the feasibility of developing an HMO." The department pointed out that a representative of HSA's Washington office had contacted the department requesting the submission of an application for a grant which would permit the Washington office to evaluate the feasibility of publicly supported HMOs. The department stated that it had grave doubts that the HMO project was feasible, but at the request of the HEW Washington office, the department was willing to study the feasibility.

The department also stated that it had repeatedly opposed the requirement to put the physicians at risk because it was (1) impossible to achieve, (2) not a basic requirement of the HMO legislation, and (3) not a part of the original grant.

Although there is support for the department's position that the project was designed to be a feasibility study, the grant application provided for a 12-month two phase study culminating in the development of a publicly administered HMO. The first phase was to include an analysis of the legal, actuarial, and organizational facets of an HMO

(feasibility study) and the second phase was to be devoted to the development aspects of an HMO. Further, the HSA letter of award accompanying the initial grant clearly indicated the development of an HMO with arrangements which would put the physicians collectively at risk. The extension of the initial grant, as well as the continuation grant, were specifically for the purpose of completing many of the steps in the development phase of an HMO.

Abnaki Health Council

This council in Claremon, New Hampshire, was formed in September 1970 to plan and develop a regional health care delivery system for the 41-town area surrounding Claremont and Springfield, Vermont. The proposed system included construction of a new regional hospital and conversion of five existing hospitals to ambulatory care facilities. In June 1971 HEW awarded Abnaki a $167,169 grant for July 1, 1971, to June 30, 1972, to develop an HMO. In June 1972 HEW awarded a continuation grant of $161,136 for July 1, 1972, to June 30, 1973. For this period, HEW also awarded Abnaki a $287,714 grant to develop a family health center.

In April 1973 Abnaki applied for $7,746 and $373,578 to continue these two grants. HEW disapproved both applications because Abnaki was not achieving program goals. Accordingly, Abnaki ceased operations on June 30, 1973, without achieving any meaningful results.

Various HMO literature indicates that organizations desiring to develop an HMO should determine at an early stage that certain necessary elements for success are present or, at least, likely to materialize. These elements, which would indicate the feasibility of an HMO, include assurances that

--enough providers (especially physicians and hospitals) can be obtained;

--a market for HMO services actually exists in the geographic area it wishes to serve; and

--support for an HMO exists among the local groups (medical society, health planning agencies, employers, unions, community organizations) in the community from which enrollment is anticipated.

Instead of determining whether an HMO was feasible, Abnaki's efforts during the first grant year were devoted to planning a new regional hospital to replace the existing hospitals in five area towns. Abnaki hired consultants to

--determine the feasibility of and location for a new regional hospital,

--identify alternative uses for the existing five hospitals,

--study ambulance service in the area,

--help develop a management information system, and

--inventory the health care personnel in the area.

Little or no effort was devoted to finding out whether physicians, hospitals, and other providers were interested in an HMO or whether there was a market for HMO services. In fact, in May 1972 a petition opposing further funding of Abnaki, signed by about 1,900 area residents, was presented to the comprehensive health planning agency. The petitioners opposed building a new regional hospital and believed that Abnaki had proceeded without sufficient community involvement and that the current health care delivery system was satisfactory.

Despite Abnaki's failure to determine whether an HMO was feasible, HEW awarded the $161,136 continuation grant in June 1972 for fiscal year 1973. This grant required Abnaki to obtain letters of commitment to an HMO from both hospitals and physicians in the area.

However, Abnaki could not obtain support from the physicians. Although some were interested in joining an HMO, this interest was based on a desire for a new regional hospital and not an HMO. Because only one of the five hospitals involved indicated support, Abnaki ceased planning for a regional hospital. As a result, the physicians lost interest in an HMO. Abnaki did sign one local physician to an employment contract in January 1973 and purchased his medical practice--the Black River Health Center. This practice was about 20 miles from Claremont, and according to Abnaki, provided medical services for 4,000 people on a fee-for-service basis. Abnaki wanted to convert these patients to a prepaid basis, but this was not done.

In addition, Abnaki made little or no progress in accomplishing other tasks necessary for a successful HMO. It did not finalize a benefit package and capitation rates, did not develop a specific marketing plan, and did not contract with hospitals to provide inpatient care.

Although Abnaki planned to market the plan mainly to seven large employers in the area, these employers were not

contacted to determine whether there was any interest in an Abnaki health program. According to Abnaki officials, Abnaki did not attempt to obtain contracts with hospitals because it had hoped that Blue Cross would bear the risk for inpatient hospital care.

Abnaki drafted a benefit package in December 1972, 6 months after the continuation grant was awarded. However, Abnaki never developed a capitation rate and could not agree with Blue Cross on the proposed benefit package or Blue Cross' financial relationships.

In May 1973 HEW disapproved another continuation grant because the previous grant goals had not been met. Subsequently, the executive director resigned and Abnaki ceased operations on June 30, 1973.

Mount Sinai School of Medicine

The Mount Sinai HMO project continued a study started in 1968 when Local 1199, the Drug and Hospital Workers' Union, asked Mount Sinai Medical Center to help develop a comprehensive health plan. Local 1199 is the sponsor for the East River Urban Renewal Project, a housing project between 107th and 111th Streets, New York City.

In June 1971 HEW awarded the Mount Sinai School of Medicine (Mount Sinai) a $53,029 grant for July 1, 1971, to June 30, 1972, to develop an HMO. The HMO project was to be a cooperative venture among the following entities, each of which was to perform the following different functions.

--Local 1199, Drug and Hospital Workers' Union, was to provide a nucleus of consumers from among its members.

--The Health Insurance Plan of Greater New York, Inc. (HIP), was to serve as the enrolling and contracting agency.

--Yorkville Medical Group (physicians) was to cooperate in the formation of a new medical group.

--Mount Sinai Hospital was to recruit physicians and provide inpatient facilities.

--Mount Sinai School of Medicine was to serve as a consultant to consumers during the planning process and to develop programs of quality assessment and consumer and provider education.

Activities during the first grant year consisted primarily of defining the responsibilities of the above entities and attempting to obtain firm commitments from each of them. Mount Sinai did not develop a benefit package or capitation rates or aline providers. Although Mount Sinai was the grantee, it did not intend to become the HMO but planned to use HIP to enroll members, collect fees, and contract with a physician group and a hospital.

HEW knew that Mount Sinai's progress during the first grant year was slow. An HEW review committee summary for Mount Sinai's application for a continuation grant, which recommended continued funding, commented that most of the year's milestones were not reached and were being proposed again; the organization was very loose and did not show strong direction; and basic issues, like finance and marketing, were left entirely to HIP. The summary also stated that a written commitment had not yet been obtained from HIP.

Despite the slow progress, Mount Sinai was awarded a continuation grant of $145,975 for July 1, 1972, to June 30, 1973. The grant required that a letter of understanding among Mount Sinai, Local 1199, and HIP be submitted to HEW to show they would work together to continue developing an HMO.

In July 1972 HIP terminated its involvement in the HMO project because of financial difficulties. In November 1972 the Associated Hospital Service of New York (Blue Cross) agreed to replace HIP. HEW regional officials agreed to accept a letter of agreement between Mount Sinai and Blue Cross as satisfying the grant condition, and in February 1973 an agreement was signed between Mount Sinai School of Medicine, Mount Sinai Hospital, the Hospital for Joint Diseases, and Blue Cross. However, this agreement was not to develop an HMO but to study the feasibility of developing a prepaid comprehensive group medical care program.

On April 11, 1973, HEW headquarters and regional office officials met with representatives of Mount Sinai, Local 1199, the Hospital for Joint Diseases, and Blue Cross to see whether their organizations were committed to actually developing an HMO rather than studying its feasibility. An HEW program analyst stated in his site visit report that:

--It was apparent that the organizations were still studying, planning, and determining feasibility, with no real commitment and no vital developmental milestones completed.

--Since the grantee never intended to become the

HMO, there is no one organization responsible for beginning to discuss contracts, develop a benefit package, plan for marketing, or make financial projections. Virtually none of this had been done.

As a result of this site visit, HEW requested by June 15, 1973, a document of intent signed by the major parties, which included (1) Blue Cross assessment of feasibility of the project and its offer to undertake enrollment and (2) a timetable for achieving major goals. HEW required this before extending the grant beyond June 30, 1973.

Mount Sinai could not obtain a commitment from Blue Cross because Blue Cross concluded from its feasibility study that there were not enough Blue Cross subscribers in the target area to guarantee the enrollment needed for a successful HMO. Consequently, the grant expired on June 30, 1973.

In commenting on our draft report in July 1975, Mount Sinai pointed out that, partially as a result of the Blue Cross study, it had recommended to Local 1199 against the feasibility of this particular poverty area HMO until the advent of some form of national health insurance.

The grantee also pointed out that the learning that took place through the HMO grant was being used in connection with certain other health related projects.

LESSONS LEARNED UNDER PRIOR HEW PROGRAM

The generator contractors were not successful in helping other organizations to develop HMOs. HEW awarded these contracts anticipating they would result in several HMOs being developed. However, two of the generator contractors visited tried unsuccessfully to develop HMOs themselves rather than assisting other organizations. One of these contractors (Penobscot Bay Medical Center) never intended to assist other organizations, because very few organizations in the State had the potential to become HMOs. The other contractor (Maryland Health Maintenance Committee) needed considerable assistance itself and wasn't technically capable of assisting other organizations. (See p. 93.)

A third contractor (Genesee Region Health Planning Council) had assisted six organizations. One of those organizations had failed to develop an HMO and two organizations were still in the developmental stages at the time of our fieldwork. Moreover, the three organizations that did develop HMOs received support from other Federal grants and only limited assistance from the generator contractor.

Although not specifically prohibited by Public Law 93-222, there is no specific provision for the generator contract approach as a vehicle for HMO planning and development. Our discussion with HEW officials have evidenced a general dissatisfaction with the effectiveness of the approach under its prior program, and we are aware of no plans to use it under the new one.

As shown in this chapter and appendix II, many of the grants expired without the grantee attaining such basic goals as developing benefit packages, capitation rates, marketing strategies, or obtaining provider or community support. An experimental program inevitably includes some failures; however, we believe that to minimize such failures, HEW should insure that grantees are making adequate progress towards their objectives, particularly before awarding continuation grants.

We believe that the basic weakness in grant review and administration under HEW's pre-Public Law 93-222 program was not the lack of information as to the grantees' progress, but rather the tendency to discount such data in an effort to make the project successful in spite of the grantee's previous performance. The fact that external factors inhibiting progress were not necessarily the grantee's fault might have contributed to this tendency.

Under Public Law 93-222, projects which receive grants or contracts for HMO feasibility surveys and projects, which receive grants, contracts, and loan guarantees for HMO planning costs, are to be completed within 12 months. No additional grants, contracts, or loan guarantees may be made nor time extensions permitted unless HEW determines that the additional funds or additional time--or both--are needed to adequately complete the project. In implementing these provisions, HEW should not make continuation grants to projects that have not made sufficient progress to warrant continued financial support.

CONCLUSIONS

Administering a grant and contract program pertaining to such a complex area as HMO development involves subjective judgment and a degree of grantee flexibility. However, to the extent that contractors and grantees were permitted to operate outside the scope of their agreements, and continuation grants were made despite a lack of solid progress, HEW's administration of the prior HMO development program was too permissive.

RECOMMENDATION TO THE SECRETARY OF HEW

We recommend that, in implementing Public Law 93-222, HEW assure that sufficient progress has been made in meeting project objectives before providing additional funds or time for feasibility studies and planning projects.

AGENCY COMMENTS

HEW agreed with our recommendation and said that it believed that the regulations and guidelines established to implement Public Law 93-222 complied with our recommendation. In addition, HEW stated that grantees were required to report quarterly on their progress so that missed milestones can be identified and corrective action taken.

CHAPTER 6

GRANTEE FINANCIAL MANAGEMENT

Although our review primarily concerned evaluating the effectiveness of programs to develop HMO entities, we did note several situations during our fieldwork which indicated that the financial management of funds by grantees needed improvement and that HEW should more closely monitor the financial aspects of grants.

Our findings included inadequate accounting and internal control systems, overcharges to Federal agencies due to errors in reporting expenditures and enrollment, charges to Federal grants or contracts for questionable items, and inadequate documentation for expenditures.

Although we noted some noncompliance with OEO requirements, OEO did have procedures requiring its grantees to obtain a certification as to the adequacy of their accounting systems and be audited annually. On the other hand, HEW did not have any procedures to insure that grantees had an adequate accounting system with proper internal controls and that only valid charges are made to the grant. Moreover, many of the HEW grantees had not been previous recipients of HEW grants under other health programs, and some apparently were formed for the purpose of receiving an HMO grant. Therefore, HEW had only limited experience or knowledge in dealing with these organizations.

HEW AUDIT EFFORT

Within HEW, the responsibility for the audits of grants and other financial arrangements with third parties (external audits) and the audits of the Department's operations and performance, including reviews of program results (internal audits), are vested in the HEW Audit Agency.

In view of the number and magnitude of HEW programs financed through grants and other third parties and of the reliance which program officials place on the external audit function to insure that program funds are properly expended and that Federal requirements have been met, the auditing of the performance and records of third parties is an important part of HEW's management control.

In August 1974, consistent with our suggestions, the HEW Audit Agency initiated an extensive audit effort involving both pre- and post-Public Law 93-222 HMO development projects. Before that time, however, as far as we could determine, the Audit Agency had not made any external audits of

the grant and contract awards pertaining to the 110 HEW projects involved in HEW's pre-Public Law 93-222 HMO development program. (See p. 4.)

This lack of audit activity pertained not only to those grant or contract projects which were not refunded by HEW, but also to those organizations that had received one or more continuation grants or contracts without benefit of audits on how they had spent the money under their previous grants or contracts.[1]

SUMMARY OF FINDINGS

On the basis of surveys of the grantees' and contractors' accounting and internal controls and limited tests of disbursements, we believed it desirable to make more detailed financial audits at seven projects.[2] Examples of our findings pertaining to the financial audits at five of the seven projects are described below.

Abnaki Health Council--HEW funded

Abnaki's accounting and internal control systems were inadequate to protect the interest of the Federal Government and to insure that grant funds were spent for intended purposes. As a result:

--The same expenses were charged to the HMO grant and to another Federal contract because the grantee's accounting system did not provide for matching expenses with funding sources. Consequently, the Federal Government was overcharged about $10,000.

--Unallowable expenses of about $5,500 were improperly paid from grant funds because the grantee's

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[1]In April 1973 an HEW Audit Agency headquarters official contacted us regarding the Agency's proposed fiscal year 1974 audit plans. The official indicated that the Agency was considering reviewing a total of nine HMO grantees in three regions to assess the results of the pre-Public Law 93-222 HMO development program--essentially an internal audit. However, after we explained to him the scope and objectives of our review, which had started the previous month, the Agency decided not to make reviews at HMO grantees during fiscal year 1974 because its planned review had objectives similar to ours.

[2]The seven projects consisted of four HEW-funded projects, two OEO-HEW-funded projects, and one OEO-funded project.

non-Federal funds, to which such unallowable expenses were to be charged, had been previously spent.

--The former executive director received about $10,700 in excess of amounts earned because of inadequate internal controls over disbursements, excessive and unsupported travel advances, and the failure to properly account for petty cash. Although the executive director resigned in June 1973, he still had not repaid about $3,500 as of April 9, 1975.

--Most expenses for travel and entertainment were not adequately documented, and some were unreasonably high in comparison with expenses authorized for Federal employees traveling under the Standardized Government Travel Regulations. For example, the former executive director made six trips and stayed overnight in hotels and/or motels with nightly rates of $32, $35, $56, $62, $70, and $76, respectively. Further, his travel expense voucher for a trip to Atlantic City, New Jersey, from November 12 to 15, 1972, included meal charges of $55.25 on November 14 and $47.90 on November 15. There was no indication of whom the meals were for or whether they involved grantee business.

We reported the results of our financial review of Abnaki to HEW's Deputy Assistant Secretary for Grants and Procurement Management, on March 7, 1974.

South Philadelphia Health Action, Inc. (SPHA)--HEW-OEO funded

When we began reviewing this grantee, its financial records were disorganized and there was a general lack of documentation for expenditures. At that time, SPHA had not obtained a certification of the adequacy of its accounting system as required by OEO. In addition, OEO guidelines were not used in performing independent annual audits and audit reports had not been submitted to OEO as required. We noted that:

--SPHA had unexpended funds of about $155,000 at the end of the first OEO grant period (June 1972) that were not returned to OEO or used to reduce the second OEO grant.

--SPHA had made questionable salary or expense payments of about $11,400 to a corporate officer and car rental payments of about $2,700, which had not been approved by OEO.

--In a report of grant expenditures accompanying the final project report for the SRS-HMO development grant sent to HEW on October 6, 1972, SPHA reported that the total grant of $62,500 had been expended by the end of the grant period, June 30, 1972. However, our review of the grantee's records indicated that only about $56,700 of the grant funds had actually been spent at that date--a $5,800 difference which should have been refunded to HEW.

We reported the results of our financial review at SPHA to the HEW regional director in Philadelphia on December 20, 1973, and corrective actions were taken, including reductions of available grant funds of about $160,800.

Penobscot Bay Medical Center--HEW-OEO funded

The first OEO operational grant awarded to the center was for $897,321 and covered July 1, 1971, to June 30, 1973. The grant provided funds to:

--Construct and operate an ambulatory care unit in Rockland.

--Pay a prepaid premium (capitation) to cover the cost of health care services to enrollees.

The center's books and records had been independently audited as required; however, principally because of a misunderstanding about how to handle the capitation funds, the first OEO operational grant was overcharged about $144,900 and interest of $2,200 earned on grant funds was not credited to the Government as required.

Grant charged for estimated instead of actual enrollment-- (resulting overcharge of $109,600)

The center estimated that by the end of its first year of operation, it would be providing services to 571 families at a monthly capitation charge of $37.22 per family. Charges to the grant were made monthly as if 571 families were enrolled. However, the monthly enrollment reported by the center was less than the estimated enrollment used to charge the grant.

As of June 30, 1973, the capitation reserve--the difference between the amounts charged to the grant and that earned based on reported enrollment--was about $109,600.

Although the grant did not specify whether estimated or actual enrollment was to be used in determining the capitation charges, OEO officials said charges to the grant should have been based on actual enrollment. They added that, if the capitation charges were based on estimated enrollment, any funds left over because of underenrollment should have been returned or reprogramed. However, the $109,600 accumulated during the prior year was not returned to OEO or used to reduce the subsequent grant.

Reported enrollment overstated--
(resulting overcharge of $7,600)

Enrollment records disclosed that actual enrollment was less than reported enrollment. For July 25, 1972, to June 30, 1973, the number of monthly capitation charges to the OEO grant exceeded the actual number of enrollees by 205. As a result, the OEO grant was overcharged about $7,600.

Single enrollees charged as families--
(resulting overcharge of $17,200)

Although the center had developed a monthly capitation rate of $15.63 for single enrollees, the family rate was used in computing charges to the grant. From July 25, 1972, to June 30, 1973, charges to the OEO grant included 795 monthly capitation charges for single enrollees at the family rate of $37.22 instead of at the single rate of $15.63. As a result, the OEO grant was overcharged about $17,200.

Double reimbursement for
Medicare and Medicaid enrollees--
(resulting overcharges of $10,500)

The center included OEO-eligible enrollees with coverage under the Medicare and/or Medicaid programs in monthly enrollment totals when determining capitation charges. According to center officials, physicians, hospitals, and the ambulatory care unit were reimbursed directly by the Medicare and Medicaid fiscal agents for services provided these enrollees. Since the health services of these enrollees were paid for by other agencies, monthly capitation charges for them should not have been made against the grant.

Enrollment of Medicare and Medicaid eligibles, who also met the OEO-income criteria, began in January 1973, and through June 30, 1973, the center had charged the grant for 283 monthly capitation charges for these persons at $37.22 each, resulting in excess charges of about $10,500.

Interest earned on capitation reserve funds

The center had earned about $2,200 by investing some of the capitation reserve funds in 90-day United States Treasury Bills. Although OEO guidelines require interest earned on OEO funds to be paid to the Treasurer of the United States, this had not been done.

We reported the results of our financial review at Penobscot Bay Medical Center to the regional health director in Boston on June 5, 1974. The regional health administrator responded in August 1974, agreeing in part, that corrective action would be taken on the overcharges of about $109,600 and that the interest earned of about $2,200 would be returned by the center to the Federal Government.

In August 1975 an HEW regional project officer advised us that action had been taken to reduce the center's subsequent grants by $144,900 and that during fiscal year 1975, the center returned interest earned on Federal funds, for the three fiscal years ending June 30, 1975, of $2,246, $22,950, and $23,950, respectively

CMA-HMO, Inc.--HEW funded

Because of weaknesses in internal control over expenditures, the lack of supporting documentation, and other problems, the financial management system of CMA-HMO, Inc., in our opinion, was not adequate for assuring that funds were properly spent.

In 1972 CMA-HMO, Inc., used a rudimentary cash basis, single-entry accounting system, which consisted of a cash disbursement journal, check stubs, bank statements and reconciliations, and canceled checks. During the second year of the grant, the grantee converted to a double-entry accrual accounting system using cash journals, general journals, and ledger accounts. However, major weaknesses still existed in internal controls and the documentation to support transactions.

--The grantee's HMO activities to be financed by the grant were intermingled with the group's ongoing fee-for-service medical practice.

--The grantee did not have a system documenting how amounts charged to the HEW grant for personnel services were determined. Charges to the grant for professional staff services were not certified as

being applicable to the grant. Charges to the grant for nonprofessional staff services were not supported by time and attendance and payroll distribution records.

--Charges to the grant for payments of $42,000 to consultants in 1972 were not supported by written agreements or detailed billing statements. These payments included about $22,000 incorrectly classified and reported as personnel services for three individuals, two of whom (involving payments of about $12,600) were on the grantee's board of directors. Prior approval by HEW was not obtained for payments to the latter individuals as required by HEW regulations.

--The grantee had no written procedures to assure that expenditures were properly authorized, chargeable to the grant, processed, recorded, and reported. As a result, accounting entries were based on oral instructions. For example, travel was not authorized in advance in writing and the costs were charged to the grant on the basis of oral instructions.

Foundation for Medical Care of Sonoma County--HEW funded

The foundation is the primary sponsor of an HMO project--the Redwood Region Health Maintenance Organization--in a three-county area in California. The grantee's accounting system had several weaknesses, including:

--Inadequate documentation of payments to the sponsoring foundations for equipment rental, administrative assistance, and consulting services.

--Inadequate procedures to control the expenditures of travel funds.

--Lack of written personnel and travel policy guidelines.

--Failure to maintain adequate records of hours worked by employees.

Although our review did not disclose misuse of Federal funds by the grantee, because of the lack of documentation

we could not verify the accuracy or the allowability of the grantee's claimed expenditures.[1]

CONCLUSIONS, PRIOR RECOMMENDATIONS, AND AGENCY ACTIONS

These findings indicate the need to assure that prospective grantees have adequate accounting systems with appropriate internal controls to protect the interests of the Federal Government, especially when the grantee is a newly formed organization.

In our March 7, 1974, report to HEW involving the Abnaki Health Council, we suggested that, before grants are awarded, there be some assurance that prospective grantees have adequate accounting systems with appropriate internal controls to protect the interests of the Federal Government. In addition, we suggested that grants be audited periodically to insure that (1) grantees' accounting and internal control systems are operating effectively, (2) adequate records are being maintained, and (3) grant funds are being adequately controlled and expended only for grant purposes in accordance with Federal grant policies.

In June 1974 HEW responded that it was undertaking a major examination and reformulation of the standards governing the procedures for

--selecting program grantees and contractors and

--effective program monitoring and grant and contract management.

Pending the results of this study, HEW said that the HEW Audit Agency would make selective preaward reviews of the financial management capacities of prospective grantees. These reviews were to consist of an assessment of the more significant business management practices of grantees and contractors, including an evaluation of their capability to

--account satisfactorily for funds;

--hire, pay, and use personnel;

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[1]In commenting on a draft of this report in July 1975, the foundation said that with the assistance of a CPA firm, the foundation's bookkeeping system had been revised to incorporate adequate accounting policies and procedures.

--control property; and

--operate a purchasing system.

HEW added that, based on these reviews, the grants officer could determine whether HEW needed to give technical assistance to the grantee or establish special controls over the grantee's activities.

In August 1974 the HEW Audit Agency and the Office of Health Maintenance Organizations, HSA, reached an agreement concerning the audits of grantees. Under the agreement, the Audit Agency would make "quick assessments" of applicants for HMO funding. These audits will be directed toward assessing an applicant's financial management capabilities before or soon after the receipt of funds. If the quick assessment indicates additional work is warranted, the Audit Agency agreed to review the grantee's financial and program operations in detail.

In addition, the HEW Audit Agency made surveys at 42 of 48 grantees that had received funds under the prior HEW program and were still active in January 1974. These surveys were directed primarily toward determining whether the grantees had appropriate financial and management systems to accomplish program objectives.

In our opinion, the actions contemplated or being taken by HEW--if properly implemented--should help to curb abuses of grants, contracts, and loans made in implementing Public Law 93-222.

CHAPTER 7

SCOPE OF REVIEW

We evaluated the effectiveness of the HEW and OEO programs in developing HMOs. Our review was made at HSA headquarters in Rockville, Maryland; HEW regional offices in San Francisco, California; Denver, Colorado; Chicago, Illinois; Boston, Massachusetts; New York, New York; and Philadelphia, Pennsylvania; OEO headquarters in Washington, D.C.; and the OEO regional office in Philadelphia, Pennsylvania.

We visited 38 projects in 14 States--California, Colorado, Illinois, Kentucky, Maine, Maryland, Massachusetts, Montana, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, and Rhode Island. We reviewed legislation, documents, reports, records, and files, and held discussions with HEW and OEO officials, grantee and contractor representatives, and officials of State Medicaid agencies and Blue Cross/Blue Shield.

The grants and contracts for the 38 projects amounted to about $33.4 million, or about 45 percent of the demonstration grants and contracts awarded by HEW during fiscal years 1971-74 and by OEO during fiscal years 1971-73. The 38 projects were initially approved during fiscal years 1971 and 1972. Several of the projects had received continuation funding during fiscal years 1973 and 1974. Of the 38 projects, 29 received funds from HEW, 6 from OEO, and 3 from both HEW and OEO.

SELECTION OF PROJECTS FOR REVIEW

Based on information obtained at HEW and OEO headquarters and regional offices, we selected 38 projects which would help us to evaluate the effectiveness of the HEW and OEO programs. Our selection included

--projects sponsored by different types of organizations (medical schools, group practices, community organizations, hospitals, and independent practice medical groups);

--projects in various geographic locations;

--projects that had developed operational HMOs;

--projects that were still trying to develop operational HMOs;

--projects whose grants had expired without resulting in an operational HMO;

--projects located in urban areas;

--projects located in nonurban areas; and

--projects funded by both HEW and OEO.

EVALUATION OF PROJECTS

We evaluated the HEW projects in terms of their ability to develop self-sustaining HMOs. We considered the following factors:

--The project's status in terms of providing services on a prepaid basis.

--The commitment of the project sponsors to the HMO concept.

--Progress made in establishing contractual relationships with physicians, hospitals, and other providers.

--Progress made in establishing contractual relationships with third parties, such as Blue Cross, insurance companies, and State Medicaid agencies.

--Marketing strategies developed and the results of marketing efforts compared to plans.

--Progress in developing financial plans, benefit packages, and capitation rates.

--The project's ability to obtain funds from non-Federal sources to help construct, renovate, or equip medical facilities and offset initial operating losses.

--Competition from more promising or established HMOs in the area.

--The project's ability to recruit qualified administrative and planning staff.

--Progress made in attaining grant objectives.

For the OEO-funded CHNs, we evaluated and classified the progress of the projects in light of (1) the original objectives of the network program as outlined in congressional testimony and other public statements of OEO officials and

(2) the objectives or goals in the OEO project grants and related grant applications.

SELECTION OF GRANTEES FOR FINANCIAL REVIEW

Although our review was directed primarily toward evaluating the effectiveness of the HMO development programs, we did survey the grantees' and contractors' financial management systems. We reviewed reports prepared by the grantees' independent auditors and made limited tests of disbursements. On the basis of problems encountered in these surveys, we believed it desirable to make more detailed financial audits at seven grantees--four funded by HEW, one funded by OEO, and two that had received funds from both HEW and OEO.

SUMMARY OF PROJECTS NOT CLASSIFIED AS EITHER POTENTIALLY SUCCESSFUL OR UNSUCCESSFUL BY GAO AS OF OCTOBER 1974

OEO INITIATED (8 projects)

1. Penobscot Bay Medical Center
Rockport, Maine

Funding

Source	Amount	Period
SRS	$ 54,240	July 1971 to Nov. 1972
OEO	85,028	July 1970 to June 1971
OEO	897,321	July 1971 to June 1973
OEO	886,765	July 1973 to June 1974

Status and problems

See pages 38 through 40.

2. Rural Health Associates
Farmington, Maine

Funding

Source	Amount	Period
HSA	$ 33,300	Feb. 1972 to June 1973
OEO	1,018,502	July 1971 to Mar. 1973
OEO	1,000,316	Apr. 1973 to Mar. 1974

Status and problems

Rural Health Associates began providing prepaid services in February 1972 to persons meeting the OEO income criteria. HSA reported in October 1974 that Rural Health Associates had 3,500 enrollees. The premiums for these enrollees had been paid with OEO grant funds. Rural Health Associates did not develop benefit packages or capitation rates for Medicaid recipients or the general public. It also did not get a reinsurance contract with Blue Cross or other carriers or a prepaid contract with the State Medicaid agency. According to project officials, State law precluded their offering their prepaid plan to the general public except through an insurance company.

3. Rochester Health Network
Rochester, New York

Funding

Source	Amount	Period
OEO	$3,234,315	July 1971 to June 1973
OEO	3,743,863	Apr. 1973 to Mar. 1974

Status and problems

See pages 31 through 33.

4. Hunter Foundation for Health Care, Inc.
Lexington, Kentucky

Funding

Source	Amount	Period
OEO	$1,836,240	July 1971 to June 1973
OEO	1,639,340	July 1973 to June 1974

Status and problems

See pages 33 through 38.

5. South Philadelphia Health Action (SPHA)
Philadelphia, Pennsylvania

Funding

Source	Amount	Period
OEO	$ 405,835	July 1971 to June 1972
OEO	2,406,897	June 1972 to July 1974
SRS	62,530	July 1971 to June 1972

Status and problems

SPHA has been negotiating a prepaid Medicaid contract with Pennsylvania since 1971, but at the time of our fieldwork, a contract had not been signed. SPHA also had not signed agreements with Blue Cross/Blue Shield to cover the risk of hospitalization and emergency services. SPHA also faced potential competition for enrollees with the HSA-funded Health Service Plan of Pennsylvania. (See p. 87.)

After our fieldwork, project officials said that SPHA had signed contracts with the State Medicaid agency and Blue Cross/Blue Shield and began providing prepaid services in April 1974. As of October 1974, SPHA had 1,400 prepaid enrollees--about 1,300 group enrollees and 100 Medicaid recipients--as compared with a projected enrollment of 3,250. HEW had re-funded the project for $2.2 million for the year ended June 1975.

6. Midsouthside Health Planning Organization, Inc. (MSHPO) Chicago, Illinois

Funding

Source	Amount	Period
OEO	$2,573,329	July 1971 to June 1973
OEO	1,043,388	July 1973 to June 1974

Status and problems

MSHPO planned to establish an HMO network by January 1973 to link four independent organizations under a common management. In July 1973 one organization began providing services on a fee-for-service basis. Marketing was to be initially directed to Medicaid recipients. However, a prepaid contract with the State had not been signed as of December 1973, although negotiations started in February 1972. MSHPO also faced potential competition for the Medicaid enrollee market from the HSA-funded CMA-HMO, Inc. (See p. 42.)

In addition, MSHPO had not contracted with Blue Cross to cover the risk of hospitalization and out-of-area and catastrophic coverage.

After our fieldwork, a project official said that as of September 1974, a prepaid Medicaid contract had not been executed. HEW had re-funded this project for $1.4 million for the year ended June 1975.

7. Ambulatory Patient Care (APC) Cincinnati, Ohio

Funding

Source	Amount	Period
OEO	$1,622,551	July 1972 to Aug. 1974

Status and problems

APC began providing ambulatory care supported on a nonprepaid basis at one of two planned centers in April 1973 and was scheduled to begin providing services on a prepaid basis in September 1973. As of December 1973, APC was not providing services on a prepaid basis. Problems included (1) inadequate startup funds, (2) no agreement with a hospital for inpatient services, (3) no prepaid contract with the State Medicaid agency, (4) no reinsurance agreement with Blue Cross or another carrier, and (5) competition from other developing HMOs in the Cincinnati area.

In addition, an APC official said he anticipated problems in marketing the plan to middle- and upper-income white people because one of the health centers is located in an area with a 99-percent black population and a high percentage of welfare recipients.

After our fieldwork, a project official said that as of September 1974, the grantee was operating two health centers on a fee-for-service basis; HEW had refunded the project through August 1975 for $1.6 million; but APC did not have a prepaid Medicaid contract with the State.

8. Sacramento Health Services Corporation
Sacramento, California

Funding

Source	Amount	Period
OEO	$ 91,235	July 1971 to June 1972
OEO	1,703,741	July 1972 to Mar. 1974

Status and problems

The corporation had hoped to begin prepaid enrollment in August 1973 and began providing ambulatory care on a fee-for-service basis at one clinic in September 1973. At the time of our fieldwork, the project had not finalized a comprehensive benefit package or capitation rates and was experiencing difficulties in recruiting physicians and contracting with hospitals. Also, it is in the same area and planned to serve the same economic population (the poor) as an operational HEW-funded foundation project whose marketing was directed to Medicaid enrollees.

In September 1974 a project official said that the project had been re-funded by HEW for about $1.3 million but had no State Medicaid contract and was not operational on a prepaid basis.

HEW FUNDED (10 projects)

1. Matthew Thornton Health Plan
Nashua, New Hampshire

Funding

Source	Amount	Period
HSA	$21,000	July 1971 to June 1972
HSA	21,375	July 1972 to June 1973
HSA	70,000	July 1973 to June 1974

Status and problems

The Matthew Thornton Health Plan was primarily a fee-for-service group practice serving about 18,000 persons. Matthew Thornton began to provide prepaid services in July 1973, and by December 1973 had enrolled only 290 of a projected enrollment of 1,500. HSA's regional technical assistance contractor concluded that Blue Cross' marketing effort was only about one-third of that planned because of a lack of manpower.

After our field review, the HEW Audit Agency reported that by August 1, 1974, the plan had 660 prepaid enrollees and 25,600 fee-for-service patients. HSA reported in October 1974 that the plan had about 700 enrollees as compared with an estimated enrollment of 3,200 by the end of the first year's operations.

2. Rhode Island Medical Society Physicians Service
Providence, Rhode Island

Funding

Source	Amount	Period
HSA	$23,250	July 1971 to June 1972 (extended to June 1973)

Status and problems

The Rhode Island Medical Society Physicians Service (Blue Shield) sponsored a prepaid group practice experiment using the Medical Associates of Bristol County

to provide services. The Medical Associates is primarily a fee-for-service group practice serving about 32,000 persons. Rhode Island Blue Shield began enrollment on a prepaid basis in May 1972 with 474 enrollees. HSA reported in October 1974 that Rhode Island Blue Shield had only 1,100 enrollees as compared with an expected initial enrollment of 4,000. Blue Shield management stopped marketing the plan to new employer groups because the plan was small; it was requiring an effort to market and other matters had more priority. The regional technical assistance contractor concluded that premarketing planning was inadequate, the medical group was not committed to the prepaid plan, and the enrollment staff was poorly trained.

3. Geisinger Medical Center
Danville, Pennsylvania

Funding

Source	Amount	Period
HSA	$126,000	Jan. 1972 to Dec. 1972 (extended to Sept. 1973)

Status and problems

See pages 40 through 43.

4. Medical Care Foundation of Sacramento
Sacramento, California

Funding

Source	Amount	Period
HSA	$122,266	July 1971 to June 1972
HSA	190,367	July 1972 to June 1973 (extended to Dec. 1973)

Status and problems

The foundation is a nonprofit corporation organized and controlled by the Sacramento County Medical Society. The foundation sponsors several medically related ventures, including a certified hospital admission program and the review and processing of Medicaid and commercial insurance claims.

The foundation's prepaid health plan was initiated in May 1972, when the foundation signed a prepaid health contract with the California State Medicaid agency. Under the contract terms, the foundation was authorized, effective July 1972, to enroll and provide medical services to a maximum of 56,000 Medicaid recipients in a five-county area.

Initially, the foundation directed its marketing efforts towards Medicaid recipients in a five-county area because (1) this group provided a large enough target population to support initial operations, (2) statistics were available on which to base prepaid rates, and (3) there was a good probability of obtaining a contract from the State. As of December 31, 1973, the foundation was providing prepaid medical services to about 36,000 enrollees, all of whom were Medicaid recipients, except for 79 persons enrolled under a prepaid plan marketed to small employers. In October 1974 the reported enrollment was about 37,000.

During the first year of operation, the foundation reported it had lost about $1.9 million under its Medicaid contract and at June 30, 1973, had claims payable of about $2.9 million. However, the foundation has only limited outside financial resources with which to help offset these initial operating losses.

5. Health Service Plan of Pennsylvania (HSP)
Havertown, Pennsylvania

Funding

Source	Amount	Period
HSA	$165,000	Jan. 1972 to Dec. 1972
HSA	234,624	Jan. 1973 to Dec. 1973
HSA	108,883	Jan. 1974 to June 1974

Status and problems

HSP's most serious problem has been the lack of adequate funds. An HSP official said that the plan could have become operational in 1971, had sufficient funds been obtained to (1) develop facilities, (2) purchase supplies and equipment, and (3) devise a full-scale marketing effort. The HSP official said the plan's inability to obtain funds was due to the refusal of the Internal Revenue Service to grant a tax exemption status under section 501(c)(3) of the Internal Revenue Code.

As of December 1973, HSP had signed agreements with two physicians' groups and was awaiting approval of the agreements by the State Department of Insurance. However, no contracts had been signed with hospitals by December 1973.

After our fieldwork, the HEW Audit Agency reported in September 1974 that HSP began providing prepaid services on April 1, 1974--the same time that the OEO-initiated CHN in the area became operational on a prepaid basis. (See p. 82.) On April 3, 1974, the State Department of Insurance recommended that HSP discontinue enrollment. HSP did this shortly thereafter, and as of August 1974 had 185 enrollees. An October 1974 HSA status report showed the plan had 233 enrollees as compared to earlier projections of 19,000 to 31,000 subscribers by the end of the first year of operations.

6. John Hale Medical Society
San Francisco, California

Funding

Source	Amount	Period
HSA	$ 25,000	Jan. 1972 to June 1972
HSA	208,104	July 1972 to June 1973
HSA	99,300	July 1973 to Dec. 1973 (extended through June 1974)

Status and problems

Initially, the society planned to enroll only Medicaid recipients. However, as of November 1973, the society had not obtained a prepaid Medicaid contract. The capitation rates computed by the society were from 20 to 45 percent higher than the maximum rates allowed by the State for prepaid plans. In our opinion, the society's financial stability could be adversely affected if it accepted the State's maximum rates.

After we completed our fieldwork, the HEW Audit Agency reported that the society had obtained a State Medicaid contract and began providing prepaid services on July 1, 1974. As of October 1974, the society had 872 prepaid enrollees--all of whom were Medicaid recipients--as compared to an expected enrollment of about 7,000.

7. CMA-HMO, Inc.
Chicago, Illinois

Funding

Source	Amount	Period
HSA	$ 98,840	Jan. 1972 to Dec. 1972
HSA	125,000	Jan. 1973 to Dec. 1973
HSA	75,000	Jan. 1973 to June 1974

Status and problems

See pages 42 through 44.

8. Rocky Mountain Health Maintenance Organization
Grand Junction, Colorado

Funding

Source	Amount	Period
SRS	$ 36,195	June 1971 to May 1972
HSA	13,000	June 1971 to June 1972
HSA	20,000	July 1971 to June 1972
HSA	210,036	July 1972 to June 1973 (extended through Dec. 1973)
HSA	80,250	Jan. 1974 to Dec. 1974

Status and problems

Rocky Mountain's marketing strategy was initially geared to recruit Medicaid recipients. Negotiations were held with the State since January 1973, and a Medicaid contract was signed in late 1973 to become effective on January 1, 1974.

After we completed our fieldwork, the HEW Audit Agency reported in September 1974 that the HMO began providing prepaid services in January 1974, and that the HMO's current enrollment was 7,350, of which 4,350, or about 60 percent, were Medicaid recipients--served pursuant to an agreement with the State Department of Social Services. Further, the HMO had negotiated agreements with the Prudential Insurance Company of America to cover (1) emergency out-of-area medical and hospital care, (2) individual catastrophic losses and high utilization of hospital services, and (3) conversions to Prudential in the event the HMO is forced to discontinue operations.

9. Nassau Medical Service Foundation
Garden City, New York

Funding

Source	Amount	Period
HSA	$ 64,000	July 1971 to June 1972
HSA	110,000	July 1972 to June 1973
HSA	33,438	July 1973 to Dec. 1973 (extended through Sept. 1974)

Status and problems

At the time of our fieldwork, the foundation had not finalized a benefit package, although it estimated a family capitation rate of about $60 to $65 per month. The foundation originally planned to be operational in September 1972, but encountered problems in obtaining an insurer for its plan. Discussions were held with eight other insurance carriers over an 18-month period before an agreement was reached with the Equitable Life Assurance Society. Equitable will market the plan, make financial plans, and assume 85 percent of the risk for hospital and out-of-area services. In November 1973 Equitable was negotiating a discount rate with hospitals. In addition, a portion of the foundation's planned service area is also served by another HEW-funded HMO.

After our fieldwork, the HEW Audit Agency reported that in September 1974, the foundation was finalizing its contract with Equitable and planned to begin operations in January 1975.

10. Hospital Center at Orange
Orange, New Jersey

Funding

Source	Amount	Period
HSA	$ 86,105	Jan. 1972 to Dec. 1972
HSA	171,723	Jan. 1973 to Dec. 1973 (extended through Dec. 1974)

Status and problems

The center at Orange initially planned to be operational in January 1973, but at the time of our fieldwork had not signed agreements with physicians, hospitals, or other providers or marketing agreements with Blue Cross/ Blue Shield.

APPENDIX I

After our fieldwork, the HEW Audit Agency reported in September 1974 that the grantee had developed a benefits package with premiums which may be noncompetitive with existing health insurance plans. Also, the center had added several physicians to the staff with the understanding that they would become employees of the HMO when it became operational. According to project personnel, the planned operational date was January 1976.

SUMMARY OF EXPIRED OR POTENTIALLY UNSUCCESSFUL PROJECTS REVIEWED BY GAO

OEO-INITIATED CHN (1 project)

1. First Maryland Health Care Corporation
   Baltimore, Maryland

   Funding

Source	Amount	Period
OEO	$ 98,880	July 1971 to June 1972
OEO	1,972,942	July 1972 to June 1974

   Status and problems

See pages 52 through 56.

HEW GENERATOR CONTRACTS (3 projects)

1. Genesee Region Health Planning Council
   Rochester, New York

   Funding

Source	Amount	Period
HSA	$250,000	June 1971 to June 1972
HSA	147,901	June 1972 to Dec. 1973

   Status and problems

See pages 56 and 57.

2. Penobscot Bay Medical Center
   Rockport, Maine

   Funding

Source	Amount	Period
HSA	$107,000	June 1971 to June 1972 (extended to June 1974)

Status and problems

See page 58.

3. Maryland Health Maintenance Committee
Baltimore, Maryland

Funding

Source	Amount	Period
HSA	$250,000	June 1971 to June 1972
HSA	300,000	June 1972 to June 1973 (extended to Sept. 1973)

Status and problems

This generator contractor attempted to develop an HMO network (one HMO with several delivery points) instead of helping other organizations to develop independent HMOs as the contract originally intended. An HEW official said that the contractor lacked the expertise to assist organizations interested in developing HMOs.

The contractor was unable to negotiate a contract with Blue Cross to act as the insurance carrier for the plan. In addition, the contractor never finalized a benefit package or developed capitation rates.

EXPIRED OR TERMINATED HEW GRANTS (13 projects)

1. Health Inc.
Boston, Massachusetts

Funding

Source	Amount	Period
HSA	$121,858	July 1971 to Dec. 1971 (extended to Apr. 1972)

Status and problems

Health Inc., was unable to negotiate prepaid agreements with the State Medicaid agency or Blue Cross. The State Medicaid agency had a prepaid contract with the Harvard Community Health Plan and was not interested in additional prepaid contracts. Blue Cross was not interested in additional prepaid contracts. Blue Cross was not interested in a prepaid agreement because Health Inc., would be serving persons covered by Blue Cross in the nongroup rather than group category.

2. Abnaki Health Council
Claremont, New Hampshire

Funding

Source	Amount	Period
HSA	$167,679	July 1971 to June 1972
HSA	161,136	July 1972 to June 1973

Status and problems

See pages 62 through 64.

3. Hunterdon Medical Center
Flemington, New Jersey

Funding

Source	Amount	Period
HSA	$99,682	July 1971 to June 1972

Status and problems

The project failed because the center's physicians opposed an HMO. According to the center director, the physicians objected because they (1) were not included in the planning, (2) did not want to be at financial risk, (3) feared loss of income, (4) feared Government control over the center's administration, and (5) believed that HMOs and prepaid plans have not worked in the United States or in other countries.

4. Mount Sinai School of Medicine
New York, New York

Funding

Source	Amount	Period
HSA	$ 53,029	July 1971 to June 1972
HSA	145,975	July 1972 to June 1973

Status and problems

See pages 64 through 66.

5. University of Kentucky Research Foundation
Louisville, Kentucky

Funding

Source	Amount	Period
HSA	$59,700	July 1971 to June 1972 (extended to Dec. 1972)

Status and problems

An advisory group of representatives from 31 organizations provided policy direction for this project. A project official said that, because of the size of the advisory group and the divergent views on health care, there was an unwillingness to allow one group to develop an HMO. As a result, the project directed its efforts toward working with several different organizations interested in developing HMOs instead of planning and developing only one HMO. The project stimulated interest in HMOs in the Louisville area, and a manual was prepared which contained a list of activities to be performed in developing an HMO.

6. Greater Woodlawn Assistance Corporation
Chicago, Illinois

Funding

Source	Amount	Period
SRS	$45,000	July 1971 to June 1972

Status and problems

The SRS grant was to partially finance the design and implementation of an HMO for the Woodlawn community in Chicago. The Greater Woodlawn Assistance Corporation was one of four organizations to be included in the Mid-southside Health Planning Organization HMO network. (See p. 83.) The corporation planned to enroll Medicaid recipients when the network organization obtained a prepaid contract. As of September 1974, the network did not have a prepaid Medicaid contract.

7. Missoula Comprehensive Health Planning Council
Missoula, Montana

Funding

Source	Amount	Period
HSA	$55,985	July 1971 to June 1972 (extended to Aug. 1972)

Status and problems

The council did not develop an HMO, primarily because of strong opposition from the local medical society. In addition, the council experienced turnover in project leadership and problems in recruiting qualified staff.

8. Denver Department of Health and Hospitals
Denver, Colorado

Funding

Source	Amount	Period
HSA	$ 80,228	July 1971 to June 1972 (extended to Feb. 1973)
HSA	121,450	Mar. 1973 to Feb. 1974 (terminated Sept. 1973)

Status and problems

See pages 59 through 62.

9. Metropolitan Denver Foundation for Medical Care
Englewood, Colorado

Funding

Source	Amount	Period
HSA	$52,550	June 1971 to Nov. 1971 (extended to Mar. 1972)

Status and problems

Although the foundation was awarded the grant, policy direction for the project came from a steering committee, consisting of representatives from various health care providers. The project experienced organizational conflicts between the steering committee and project staff. The project ended in March 1972 without producing specific plans to develop an HMO.

10. St. Josephs Hospital
San Francisco, California

Funding

Source	Amount	Period
HSA	$25,000	Jan. 1972 to Mar. 1972 (extended to June 1972)

Status and problems

The major effort of this project was directed toward determining the interests of the hospital's medical staff in forming a medical group. A consultant hired for this purpose indicated that the hospital medical staff would not support an independent HMO at the hospital. Reasons cited by the consultant included:

--The physicians were unwilling to accept the financial risks involved in forming a medical group.

--The physicians were committed to the local medical society's foundation.

--The physicians believed that there were already too many HMOs in the area.

11. Martin Luther King Health Center
Bronx, New York

Funding

Source	Amount	Period
HSA	$57,689	July 1971 to June 1972
HSA	63,408	July 1972 to June 1973
HSA	34,542	July 1973 to Dec. 1973 (extended through June 1974)

Status and problems

This project was an OEO-funded neighborhood health center providing care to about 38,000 residents of south Bronx. The HSA grants were for converting the center from a fee-for-service operation to a prepaid system. Marketing strategy was geared mainly to Medicaid recipients. Although the center had been negotiating with both the city and State of New York since March 1972, a Medicaid contract had not been signed as of December 1973. Major negotiating issues were (1) whether the

State would guarantee enrollment for 6 months, even if a person becomes ineligible for Medicaid during that period, and (2) the capitation rates. The center had estimated a monthly rate of $36 per individual and $111 for a family of four.

After our fieldwork, the HEW Audit Agency reported in August 1974 that the prepaid Medicaid contract had not been finalized, although the center had reduced the estimated monthly capitation rates to about $29 for an individual and $105 for a family of four.

12. New York City Health and Hospitals
New York, New York

Funding

Source	Amount	Period
HSA	$100,000	July 1971 to June 1972 (extended through June 1974)

Status and problems

Although initially funded in 1971, this project was still in the early stages of development. It has had three directors, and as of October 1973, still had not decided on a location for the HMO. A proposed benefit package had been developed but a capitation rate had not been determined.

After our fieldwork, the HEW Audit Agency reported that the project had terminated on June 30, 1974, with little, if any, progress toward the forming of an HMO.

13. Foundation for Medical Care of Sonoma County
Santa Rosa, California

Funding

Source	Amount	Period
HSA	$102,750	July 1971 to June 1972
HSA	128,206	July 1972 to June 1973
HSA	41,254	July 1972 to June 1973 (extended through June 1974)

Status and problems

The purpose of the latter two grants was to develop the planning and marketing of a prepaid plan for

Government programs, commercial groups, and individual residents with accessible, economical, and high quality health care for subscribers. Although the grant period was extended to June 1974, the foundation failed to meet the project objectives.

The foundation had signed an experimental contract with the State Medicaid agency, effective September 1973, to provide health services on a prepaid basis to Medicaid recipients in three counties. The Medicaid recipients were automatically enrolled and no marketing was necessary. The foundation had not developed a benefit package, capitation rates, or a marketing plan for groups other than Medicaid recipients.

After our fieldwork, the HEW Audit Agency reported in September 1974 that the grantee appeared to show little interest in expanding its activities to provide for other than services provided to Medicaid enrollees by its existing contract. The foundation informed the Audit Agency that it had no current plans to enroll subscribers on a voluntary basis.

EXPERIMENTAL HEALTH SERVICES CONTRACT (1 project)

1. Philadelphia Health Management Corporation
Philadelphia, Pennsylvania

Funding

Source	Amount	Period
HSA	$525,000	June 1971 to June 1973 (Extended to Sept. 1975)

Status and problems

The Philadelphia Department of Public Health was awarded a contract for $1,225,000 under the Experimental Health Services Delivery Systems program. Under the contract, $525,000 was designated for HMO development. The city of Philadelphia carried out the contract until November 1972, when it was transferred to a separate corporation--the Philadelphia Health Management Corporation. As of June 30, 1973, only $22,000 had been allocated to HMO development. The corporation planned to assist other developing HMOs in the Philadelphia area by providing funds and technical assistance. However, as of September 1973, the corporation was still performing basic planning related to HMO development.

APPENDIX II

After our fieldwork, the objectives and scope of the contract were modified in June 1974 to provide support in enhancing community understanding of the HMO concept. As of October 1974, about $150,000 had been expended in making a film and educating providers and businessmen on the advantages of HMOs.

APPENDIX III

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

JUL 2 2 1975

Mr. Gregory J. Ahart
Director, Manpower and
Welfare Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report to the Congress entitled, "Effectiveness of Grant Programs Aimed at Developing Health Maintenance Organizations and Community Health Networks." They are enclosed.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

John D. Young
Assistant Secretary, Comptroller

Enclosure

APPENDIX III

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE COMMENTS ON GAO DRAFT REPORT TO THE CONGRESS ENTITLED, "EFFECTIVENESS OF GRANT PROGRAMS AIMED AT DEVELOPING HEALTH MAINTENANCE ORGANIZATIONS AND COMMUNITY HEALTH NETWORKS"

GENERAL COMMENTS

We have the following comments on the draft GAO audit report.

We are in general agreement with the draft report. The conclusions reached based on the review of organizations funded to develop HMOs are essentially accurate. We learned much from the funding activity which took place prior to the enactment of the HMO Act of 1973. As a result of this experience the Act and the regulations and guidelines written to implement the Act provide for a more orderly progression of activities leading to the development of an HMO than was the case in the pre-Act activities. At each of the three levels of funding, i.e., feasibility, planning, and initial development, specific activities are required and certain output requirements have been specified. An organization must complete each activity and provide certain output data which are evaluated before they can receive additional funding.

We would like to point out that the Community Health Networks (CHN) were originally funded under Section 222a(4)(a) of the Economic Opportunity Act which restricted the use of funds to benefit persons who were eligible under OEO Income Guidelines--OEO Instruction 6128-1. It was not the intent of the agency that services within CHNs be limited to only the economically needy, but rather to develop a system of organized services within the community consistent with agency guidelines and not discriminating against those who are economically needy.

Our comments on the specific recommendations made in the report are as follows:

GAO RECOMMENDATION

"To minimize the impact of unanticipated under enrollments of developing HMOs, we recommend that in implementing Public Law 93-222, HEW (1) emphasize pre-operational marketing and enrollment activities and/or (2) make operational loans conditional upon an HMO reaching a minimum enrollment level within a specific time."

DEPARTMENT COMMENT

We are in general agreement with the thrust of both of these recommendations and feel that the regulations, guidelines, and procedures established to implement the Act accomplish the intent of these recommendations without additional changes being required.

In regard to part (1) of the recommendation, the funding under the initial development grant authority of Section 1304 of the HMO Act is adequate for testing consumers attitudes and the development and testing of marketing strategies. Specifically, some of the activities during the initial development phase which are followed under the guidelines are:

1. Preparation and distribution of promotional material.

2. Hiring of market representatives. (This would also include training of such persons).

3. Development of forms and procedures.

4. Negotiation of group contracts.

5. Development of open enrollment strategy.

During the initial development activity HSA monitors closely the progress of the plan in developing its marketing capability. These activities coupled with the provision in Section 1310 of the Act requiring employers to offer the HMO as an optional health benefits coverage and the increasing awareness of HMOs among employers and the public should assure better marketing efforts than in the past.

In regard to part (2) of this recommendation, we do not agree with this specific approach. An organization can be found to be a qualified HMO and an operational loan awarded prior to the organization becoming operational. In many cases this will be necessary to assure that the plan will have adequate financial backing to enroll persons and become operational. To deny them the assurance of such financial backing would place them in an untenable position. However, the decision to award a loan is contingent upon our evaluation of the marketing forecast proposed by the applicant. After the loan is committed we monitor closely the progress of the enrollment efforts by the HMO. If the HMO's enrollments fall behind its projections, HEW will provide technical assistance to change their marketing approach and techniques. If the HMO continues to fail to meet the necessary enrollment goals which brings into question their ability to become a viable organization, the project can be terminated. This would result in a minimum drawdown on the principal amount of the loan. It is important

APPENDIX III

that flexibility be shown in the financial projections so that costs can be repaid in the event of a lag in enrollment so that an unnecessarily high deficit is not encountered.

We believe this approach meets the general intent of part (2) of the recommendation in that it allows us to commit a loan before the plan becomes operational while we continue to monitor the enrollment progress against projections. If the plan fails to meet enrollment projections to a significant extent, action can be taken to terminate the project and withdraw the balance of the loan.

We also call attention to the fact that the final HMO contracting regulations published May 9, 1975, contain a requirement that a State Medicaid agency must determine that an HMO with which it contracts has made adequate feasibility and planning studies to assure the enrollment of a sufficient number of members to assure economic viability (45 CFR 249.82(c)(6)(ii)).

GAO RECOMMENDATIONS

"In considering grants, contracts, or loan guarantees for the initial development of HMOs under Public Law 93-222, for those applicants whose marketing plans contemplate the use of third parties such as health insurers, HEW should give strong consideration to requiring such applicants to provide the third parties with appropriate financial incentives for successful performance."

DEPARTMENT COMMENT

We do not agree that we should require HMOs using third party marketing agents to provide the third parties with financial incentives for successful performance. The involvement of carriers with substantial resources and access to the marketplace can be a most important factor in the growth and financial viability of a new HMO. We agree that to capitalize to the maximum on carrier resources the carrier should have real incentives for successful performance. This approach has been and will continue to be encouraged for grantees in our review of their marketing plans. However, it might not be possible for a plan to secure an agreement with a carrier containing such provisions and the advantages of having a marketing agreement with such carrier could outweigh the disadvantage of not being able to include such provisions in the agreement. Therefore, we believe each case should be reviewed individually with HMOs encouraged to include such incentives wherever possible.

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GAO RECOMMENDATIONS

In connection with the continued funding of Community Health Networks projects, we recommend that HEW re-examine the feasibility of the CHN approach as an HMO-type organization in light of the lack of progress in meeting the HMO objectives and consider redefining the objectives of such projects.

DEPARTMENT COMMENT

The Community Health Center Program Office is re-examining the feasibility of the CHN and Family Health Center concepts. Specific Program Indicators are being developed for these activities. Projects unable to comply with these Program Indicators will be assessed to determine if there is a continued need for Federal funds to support ambulatory care services within those communities. If so, such direction will be given the grantee organization. The Ambulatory Patient Care, Inc. project in Ohio and the Penobscot Bay project in Maine are currently being re-examined. All similar projects will be so examined during fiscal year 1976.

GAO RECOMMENDATION

"In considering grants, contracts, or loan guarantees for the planning and initial development of HMOs under Public Law 93-222 we recommend that HEW avoid

--situations where the project's initial marketing strategy is geared solely or principally to Medicaid recipients;

--funding the development of competing HMOs in the same area where the HMO is not already accepted by the community."

DEPARTMENT COMMENT

We agree that to the extent possible we should not fund organizations which intend to market principally to Medicaid recipients and we can not fund organizations which intend to market solely to Medicaid recipients. Both the Act and the regulations recognize this principle. The Act provides in Section 1301(c)(3) that the HMO must enroll persons who are broadly representative of the population within its service area but cannot enroll more than 75 percent of its members from a medically underserved population unless the area in which such population resides is a rural area. Section 110.109(c) carries this concept further by stating that persons entitled to benefits under Medicare or Medicaid cannot comprise more than 50 percent of the plan's enrollment unless the Secretary grants a waiver for good cause.

APPENDIX III

It is necessary to recognize, however, that the Act calls for priority in funding projects that will serve populations from medically underserved areas. Since no subsidy is provided, virtually the only urban populations which qualify as medically underserved are those which are heavily supported by Medicaid. Such projects must provide acceptable plans for the enrollment of employed persons. The validity of such plans is difficult to assess in view of the problems which have been observed in the enrollment of employed persons in what is considered by outsiders as a "poor people's" HMO. In every instance such projects are urged to initiate private enrollments first. In the face of the need for real health care in these areas and of the statutory priority for medically underserved areas, it does not appear possible under the Act to deny a well-documented application.

As to the second part of this recommendation that HEW avoid funding the development of competing HMOs in the same area where the HMO concept is not already accepted by the community, we cannot agree with this as a blanket requirement. We believe there are several factors which must be considered before arriving at a determination as to whether to fund more than one project in an area. Some of these considerations are:

1. The size of the population in the proposed area.

2. The income level of the population in the area.

3. The types of proposed organizations, i.e., group practice or individual practice.

4. The level of funding, i.e., feasibility, planning, or initial development of the respective organizations. For example, it may be appropriate to fund two feasibility studies in the same area but not two initial development projects.

All of these and other factors are taken into account in determining whether a grant award should be made in an area where there are other operating plans or grantees. However, it is not our intent, nor do we believe it is the intent of the Act, to by our actions give an exclusive franchise to any organization where there is evidence that an area can support more than one plan. In addition, Section 1310 of the Act requires that an employer must offer both a medical group and an individual practice HMO where both are available. Therefore, it appears contrary to the intent of the Act to deny funding to one project when one of the other types is already active provided that the target population is large enough to support more than one. In two areas, Rochester, New York, and Alburquerque, New Mexico, HMOs of the group practice and individual practice types are competing. Both are gaining enrollment and show every evidence of becoming viable plans.

GAO RECOMMENDATION

"We recommend that, in implementing Public Law 93-222, HEW should

--assure that sufficient progress has been made in meeting stated project objectives before providing additional funds or time for feasibility studies and planning projects."

DEPARTMENT COMMENT

We agree completely with this recommendation and believe our regulations and guidelines already require this. Under those regulations and guidelines, specific output requirements have been established for each stage of funding. When a project applies for the next higher stage of funding, the applications must contain the results of the activity at the lower level. These are reviewed to assure that the plan has adequately completed each activity and that the required outputs are shown. Only after we are assured that all activities on the prior grant have been carried out and the project appears to have the potential of becoming a viable HMO will we approve funding at a higher level. If all activities on the prior grant have not been accomplished, we can award another grant at the same level or extend the grant period but only if we are assured that the project is making progress and that given the additional money or time has the potential of becoming a viable HMO.

In addition, projects are required to report quarterly on their progress under the grant so that missed milestones can be identified and corrective action taken. In this way, we try to assure that projects are making progress and will finish the required activities within the time and the budget allocated. Projects which are not making satisfactory progress can be identified and corrective action taken or the project can be terminated.

TECHNICAL COMMENT

The second paragraph on page 17 indicates that under Medicare, "The law and proposed implementing regulations provide two reimbursement systems--one for 'mature' HMOs and one for 'developing' HMOs." The last paragraph on the page goes on to describe minimum enrollment and operating experience requirements for mature HMOs in support of the report's recommendation that HEW make operation loans conditional upon an HMO meeting a minimum enrollment level within a specified period of time. These statements in the report accurately reflect the proposed regulations on qualifying conditions for HMOs that were published in the Federal Register several months ago. However, they are not in accord with the revised version of these regulations which was approved June 19, 1975 by the Secretary for publication in the Federal Register in final. Therefore, we suggest that the last four sentences of page 17 of the draft report be corrected to read as follows:

"The law provides two reimbursement methods for HMOs--incentive reimbursement and reasonable cost reimbursement. Under the incentive reimbursement option, savings the HMO achieves under a formula in the law are shared, subject to certain limits, between the HMO and the Medicare program."

"In order to qualify for incentive reimbursement, certain statutory requirements related to enrollment levels and operating experience must be met. An HMO in an urban area must: (1) have been the primary source of health care for at least 8,000 persons in each of the 2 years immediately preceding the contract year, and (2) at the time of the contract with HEW have a minimum of 25,000 enrollees. The related statutory requirement for an HMO in a nonurban area is: (1) that it have been the primary source of care for at least 1,500 persons in each of the 3 years immediately preceding the contract year, and (2) at the time of the contract with HEW have a minimum of 5,000 enrollees. Medicare's proposed final qualification regulations for HMOs also establish a minimum enrollment requirement of 5,000 prepaid members for HMOs that are reimbursed on a cost basis. Developing HMOs are given 3 years to reach this level of enrollment. The regulations also permit the 3-year period for meeting this requirement to be extended by the Secretary under certain limited circumstances."

PRINCIPAL OFFICIALS

OF THE FEDERAL AGENCIES

RESPONSIBLE FOR THE ADMINISTRATION OF ACTIVITIES

DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE		
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
David Mathews	Aug. 1975	Present
Caspar W. Weinberger	Feb. 1973	Aug. 1975
Frank C. Carlucci (acting)	Jan. 1973	Feb. 1973
Elliot L. Richardson	June 1970	Jan. 1973
ASSISTANT SECRETARY FOR HEALTH (note a):		
Theodore Cooper (acting)	Feb. 1975	Present
Charles C. Edwards	Mar. 1973	Jan. 1975
Richard L. Seggel (acting)	Dec. 1972	Mar. 1973
Merlin K. DuVal, Jr.	July 1971	Dec. 1972
Roger O. Egeberg	July 1969	July 1971
ADMINISTRATOR, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION (note b):		
Harold O. Buzzell	May 1973	June 1973
David J. Sencer (acting)	Jan. 1973	May 1973
Vernon E. Wilson	July 1970	Dec. 1972
ADMINISTRATOR, HEALTH SERVICES ADMINISTRATION (note b):		
Robert Van Hoek (acting)	Feb. 1975	Present
Harold O. Buzzell	July 1973	Jan. 1975

	Tenure of office From	To
OFFICE OF ECONOMIC OPPORTUNITY (notes c and d)		
DIRECTOR:		
Alvin J. Arnett (acting)	June 1973	July 1973
Howard Phillips (acting)	Jan. 1973	June 1973
Phillip V. Sanchez	Sept.1971	Jan. 1973
Frank C. Carlucci	Dec. 1970	Sept.1971
ASSOCIATE DIRECTOR, OFFICE OF HEALTH AFFAIRS:		
Jeffrey Binda (acting)	Feb. 1973	July 1973
E. Leon Cooper, M.D.	Nov. 1971	Feb. 1973
Carl A. Smith, M.D. (acting)	May 1971	Nov. 1971
Thomas E. Bryant, M.D.	Sept.1969	Apr. 1971

[a]Title of office was changed from Assistant Secretary for Health and Scientific Affairs in November 1972.

[b]Effective July 1, 1973, the HSMHA was abolished and the Public Health Service was reorganized into six health agencies under the direction and control of the Assistant Secretary for Health. Most HSMHA functions were transferred to four new agencies: the Center for Disease Control; the Health Resources Administration; the Health Services Administration; and the Alcohol, Drug Abuse, and Mental Health Administration.

[c]Name of agency was changed from OEO to Community Services Administration by Public Law 93-644, approved on January 4, 1975.

[d]Effective July 6, 1973, responsibility for the Comprehensive Health Services program was transferred to HEW.

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